A Process of Restructuration of Oslo University Hospital.

A qualitative study of the merger of the University Hospitals of Oslo and gradual changes of the organisational model discussed and implemented by the Hospital.

Magda Filonowicz

Master Thesis

Institute of Health Management and Health Economics

UNIVERSITETET I OSLO

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1. INTRODUCTION

1.1. The Background of the Study

After the Hospital Reform of 2002, the Norwegian State took control over and the responsibility for the secondary health care services, previously subordinated to the County Councils. Further, the hospitals were organised as economically independent legal subjects, named Health Authorities (HA). The HAs based on their geographical localisation, were subordinated to one of the Regional Health Authorities (RHA). The RHAs had the main voice in what it concerned the organisation of HAs. There were created five RHAs in Norway, named respectively North, South, East, West and Middle-Norway. However, on the 1st of June 2007 South and East RHAs merged into South-East RHA, which became the biggest of the four Norwegian RHAs. This particular RHA consisted of following thirteen HAs: Akershus University Hospital, Aker University Hospital, Ullevål University Hospital, Rikshospitalet (merged with Radiumhospitalet on the 1st of January 2005), Psychiatry in Vestfold, Sunnaas Hospital, Hospital Pharmacies, Hospital in Vestfold, Hospital Innlandet, Hospital Telemark, Hospital Østfold, Sørlandet Hospital, Vestre Viken.

In the spirit of fusion of RHAs it appeared to be desirable to create HAs mergers in the capital city. The subject of my inquiry is the recent fusion of three independent HAs, Aker Hospital HA, Ullevål University Hospital HA, Rikshospitalet, situated in the city of Oslo, and subordinated to Health South-East RHA. The three above mentioned Hospitals merged together into Oslo University Hospital (OUH) on the 1st of January 2009. The facility currently employs over 20.000 employees and offers medical services to the local inhabitants of Oslo and Follo, as well as highly specialised medical services to the entire South-East region and other parts of the country. OUH is considered to be the biggest academic environment of medical professionals in Norway.

I was employed at the Ullevål University Hospital in Oslo from mid-March 2009 to August 2010. During that time a large merger of the University Hospitals of Oslo was being implemented and developed. I actively followed the evolution of the process by participating in the focus groups' meetings and reading the chronologically published internal documents

addressed to the hospital staff. After several months, I realised that the series of published documents and speeches included several inconsistencies and major generalizations.

The above-mentioned inconsistencies arose firstly between the macro- and micro-administrative levels by which I mean between RHA and HA. The reorganizational models evaluated by South East RHA in period April-October 2008 resulted in a strong recommendation on merging the three University Hospitals of Oslo and assigning a local hospital function to specifically one of them as well as reducing the overall operative surfaces. However the final recommendation did not specify in which geographical position the local hospital function was to be established or reinforced, neither which specific surfaces were to be reduced.

Further inconsistencies arose at OUH's level and consisted of differences between the model initially chosen by OUH and the one that was finally implemented. During the OUH's board meeting of June the 2nd 2009, the Administrative Director (AD) Siri Hatlen introduced to the audience the drafts of three alternative organisational models that were to become a basis of further internal process of restructuring. Neither of these drafts presented a net image of the existing infrastructures or the physical building-mass consisting of as many as four hospitals (two of which had been previously merged). However, the two of three models were in line with the general frames recommended by the RHA. They presented a clear geographical separation of the local hospital function from both regional and national functions by assigning it to a separate hospital structure. AD expressed her introductory choice of one of the models in June 2009. The chosen model appeared to be in line with the recommendations of RHA as it placed most of the local functions within one single hospital. However the model did not specify which of the hospitals was to carry the responsibility for this function.

A further specification of local hospital's function and its' localisation became a subject of a public consultative round initiated by OUH in Autumn 2009. During the consultative round it became evident that most of the actors agreed with the RHA's initial recommendations and desired a clearly separated local hospital function placed in an independent hospital unit. Many of the consulted bodies wished that this function was placed at former Aker University Hospital. Finally, the AD chose a model specification that implicated the shutting down of Aker University Hospital and the allocation of local hospital function throughout the ten merged clinics situated across Ullevål University Hospital and Rikshospitalet.

1.2. Delimitation and research question

The reorganization of OUH represents a long-run process of important change. I do recognize the complexity and impact of the surroundings on the process of reorganization of OUH. Although OUH is an independent economic body, it is still owned by the State and partly controlled by the Health South East Regional Authority. An important part of the predetermining principles for the current fusion and reorganization originates from the processes undergone at the heart of South East RHA in 2005. I wish to gain a further insight into the process discussed not only by identifying the overall principles underlying the process, but also by interviewing the administration of the OUH and representatives of the City Council of Oslo.

The main goal of this thesis will be the analysis of the process of reorganization of University Hospitals of Oslo initiated at the level of the South-East RHA and developed at the level of the Oslo HA. A particular attention will be paid to the major inconsistencies between the underlying premises for the process and the choice of the organizational model, as well as between the organizational model initially chosen by OUH and the one that was implemented. Through the above-defined analysis I wish to unfold the reasons underlying the choice of the actual organizational model adapted by OUH.

A study of a process of reorganisation of a public hospital and the inconsistencies arising throughout the process appears interesting for many reasons among which I consider particularly important the quest for providing a thorough explication of the process and its' consequences to the public involved. The entire process attracted a lot of public attention and has been a topic of intense debates from the very beginning. The closing-down of one of the hospitals caused a lot of tensions and remains for many patients and other public observers an inexplicable choice. By providing a chronological and accurate description of the process I hope to be able to clarify the shares of the responsibility for different elements of the process as well as to unfold the underlying reasons for the implemented decisions.

The previous studies that examined the processes of restructuration of health care system in Norway were conducted by both Tjerbo (2009) and Nerland (2007). Both these PhD thesis examined how the Hospital Reform of 2002 influenced the administration of secondary health services. Tjerbo analysed the interrelations between primary and secondary health care services, while Nerland looked in particular at secondary health care services and the

deployed by RHAs and HAs organisational solutions prior to the Reform. The studies show that the governmentalization of the ownership of the public hospitals failed to simplify and unify the major decision making processes concerning the structural matters in public secondary health care services. They also show that the government's suggestions were not always followed by RHAs or HAs.

In this thesis I will analyse the process of reorganisation of three public University Hospitals of Oslo. I will briefly look at the incentives given by State; thoroughly examine the formal framing of the process at RHA's level and the further evolution of the process at HA's level. I will particularly observe the inconsistencies that arose between the different administrative levels as well as the inconsistencies that arose within the administrative level of the HA.

The thesis will be plotted around four major theories of organisation. Firstly, Scott's description of rational, natural and open organisations. Secondly Boulding's hierarchization of the above mentioned organisational systems and Thompson's theory of contingency. And finally, Brunnsons theory of hypocrisy that focuses on the changes over time of the given organisational system that reflect the inconsistencies between talk, decision and actions involved in the process of reorganisation. I will analyze the different stages of the process of restructuration of OUH in light of the above-referred paradigms. Finally I will provide the most relevant fragments of the conducted elite interviews in order to answer the following research question: *Why did Oslo University Hospital adapt its' present organisational model?*

1.3. Theoretical background

The most schematic principles for hospitals' reorganisation, describe how the individual hospitals or departments can be clustered on the basis of geographical adherence, clientele (here: patients), function or process. This classification is useful both for constructing of the organisational models as well as for interpreting the existing models. The analysis of the organisational models appearing at the separate stages of the process of reorganisation will be the core element of this thesis.

I will begin by introducing Scott's interpretation of basic four organisational archetypes: rational, natural, closed and open systems. The ideology of a rational system takes it sources from the early age of industrial sector. It implies that an organisation can be programmed to

give a specific and measurable outcomes, and its' only correlation with the external world consists of intake of necessary resources. A rational organisation operates optimally in stable and predictable environments. If the environments are dynamic and not fully predictable, then the organisation that wants to survive needs to take conscious of these environmental fluctuations. The organisation will need to accumulate the information about the surrounding environments as well as to emit some information about itself to the external world. This type of organisation will most often be described as a natural system consciously interacting with the outside world. Further, both rational and natural organisations can be of either closed or opened character, implying a grade to which the organisation is both influential on the relevant environments and responsive to the input arriving from these environments. The closed systems will be respectively those that are little influential and responsive, while the opened systems are highly influential and responsive.

Boulding's classification of organisational systems places the rational and closed systems on the bottom of the hierarchy, while presents the open natural systems as the ideal archetype due to its' high interaction rates with the external world. According to this ideology, an active interaction with the surroundings proves an extraordinary organisational flexibility and ability to adapt to the changing environments, which in its' turn guarantees the highest survival rates of a given organisation.

The hospitals do operate in highly dynamic environments therefore it should be desirable to achieve a high placement in the Boulding's hierarchy of organisational systems. That means that ideally the hospitals shall be open organisations. However, both rational and natural systems can to some extent adapt to the environmental dynamics. The transformation of a given organisation from a close to an open system or in some circumstances the other way around, allows to operationalize its' decisions and to produce action.

Many organisations will change their system-profile over time. I will use Brunnsons theory of Organisation of Hypocrisy as well as Thompson's theory of Contingency to examine the inconsistencies arising between the different organizational levels and at different stages of the process of restructuration.

Throughout the early stages of the process of reorganisation, OUH manifested a resemblance to a closed rational system, while during further stages of the process it might have been characterised as an open rational system. The changes of the character of organisation over time could be interpreted as the inconsistencies between talk, decision and action or in terms

employed by Nils Brunnson, as organisational hypocrisy. Brunnsons states that in some periods of organisational existence, the decision makers will consciously choose to rationalise and lock the system mainly in order to produce measurable results such as a solid infrastructure for the planned production. At this stage of the organisational existence, the decision makers will not be particularly interested in the signals arriving from the surrounding environments. However the organisation may deploy a series of strategies to maintain an access to the resources needed for its' further existence and controlled by the surroundings. One of the main tactics would be to produce more of talk and less of action. This will be usually the strategy at the level of decision-making and founding of solid basis for a future action.

I will attempt to prove that the choice of the organisational model implemented by OUH was a proof of the organisational rationality and purposely limited openness. The limitation of responsiveness to the external influences according to Brunnson might be an attempt to guarantee the implementation of the new structures. I will also attempt to uncover the improvements of OUH's ability to process the inputs from the external environments during the further stages of the process of restructuring. The process of reorganisation contained the inconsistencies or the elements of organisational hypocrisy that should be understood as a part of its' conscious survival strategy.

1.4. Methodology

The methodology that I chose for the conduct of the present study builds upon collection and analysis of qualitative data gathered from both written sources and oral interviews conducted with representatives of top management of OUH.

The analysis of the collected information is based on general identification of relevant archetypes of reorganizational models as described in a selection of theories presented in Chapter 2 and further, the attempt to match the identified theoretical models to the actual organisational forms adapted by OUH at different stages of its' process of reorganisation. I will identify the theoretical archetypes that are most similar to the existing organisational structures adapted by OUH chronologically throughout the process of restructuration. Theoretically the various organisational models might be placed in a hierarchical order (respectively: closed-rational, closed-natural, open-rational and open-natural, as described in

section 1.3). It shall be of interest to verify whether the latest organisational form adapted by OUH is superior or inferior to the previous forms, in terms of placement on Boulding's classification scale.

2. THEORETICAL BACKGROUND

The process of restructuring of the University Hospitals of Oslo needs to be approached from an adequate theoretical perspective. Although many theories of organisation could be argued to be equally suitable, I have decided to frame my work into W. Richard Scott's classical description of organisations as rational, natural and open systems, Boulding's hierarchisation of various organisational structures as well as Nils Brunssons theory of Organisation of Hypocrisy and Thompson's theory of contingency. This particular choice seemed most relevant, since the process of reorganisation was still in progress at the time of submission of this thesis and we could clearly distinguish between its' stages. In line with the chosen theoretical approach, the gradual stages of reorganization shall be understood as stage of talk, decision-making and action leading either to organisational development or degradation. The intriguing boundaries separating each of the phases of reorganisation deserve our highest attention as they may relieve the notorious brunnsonsian" hypocrisy", unintended and yet unavoidable dissonance between talk, decision and action, revealing the decision-maker's intentions. We will also observe the interaction between the organisation and its' environment, and we shall be able to identify ways of embracing the arising inconsistencies by including these into the stage of talk but not necessarily transferring them into the stage of decisions. We will also see how some of the omitted environmental voices could reappear in the stage of action-taking and even change the direction of what had been decided by making it impossible to be implemented. The key element of my analysis will be the identification of the grade of openness of the organisation in study, which I will attempt to uncover through the analysis of the elements of organisational inconsistencies. I claim that the grade of openness of organisation is particularly detectable through the observation of the stage of introductory talk, and in particular the presentation of available models of reorganisation. Depending on the accuracy and objectivity of the models' presentation, the inconsistencies arising between what was initially presented at the talk stage and what was further discussed and decided will be either a proof of organisational evolution or degradation. In other words the arising hypocrisy would be either of traditional and morally dubious sort, or of brunssonian innovative and morally legitimate kind.

2.1. Organizations as Rational Systems

The rational perspective views the organisations as the mechanical bodies designed to attain a set of predefined goals. This rather technical interpretation of organisations, builds on assumption that human beings are just a replaceable part of the machinery and the machine runs smoothly as long as the necessary parts are on the right place in the right time. Different pieces of organisational machinery not only can be used in different than the initial settings but can as well be replaced. The different pieces are merely loosely coupled. This perspective underestimates the human factor as such and assumes that as long as the purpose of running an organisation is explicit to the individual joints creating the organisation, these would have to adapt to any function within the organisational settings. Otherwise they will finish by being replaced by new joints. Members of any given rational organisation have thereby only one set of objectives to pursue and these are equal to the objectives manifested through the formal structure of the organisation.

According to Simon's theory of organisational behaviour, a successful organisation is the one that facilitates and supports the decision of its' participants essentially through limiting the number of choices that the participants may anticipate. This again strengthens the power of the entire machine but weakens the position of the individual links. Human beings are merely the tools of some abstract goal achievement process led by "the invisible hand" and they do not possess the autonomy of changing the course of organisational action.

Not much is said about who decides on the purpose of the existence of the organisation, which is one of the main weaknesses of this theoretical approach. We do not really know whether the goal setting foregoes within the organisation and in such case on which level of the organisational structure, or whether the goal setting is an external process that happens beyond the machine's structures. Either way, it appears that human beings' functioning as a part of a given organisation has no major influence on the course of action. Their choices are limited by the restricted access to strategic information which guarantees that whoever is leading the organisation will achieve only what is planned in advance. The labour is not allowed to take the lead of the organisation. The surroundings of the organisation are also underestimated in rational systems' theory, no interaction between the organisation and the outside world is formally recognised.

To reassume, the rational perspective states that the organisation can be designed in a purely rational process and regardless of the external environment. Rational systems' theory disregards the influence of both the internal and the external activities on the overall organisational goals and through this negligence it implies that organisations do not evolve intact with the movements of the majority, neither of the labour nor of the society. However, given that both the internal and the external environments are constant their dynamics can be legitimately disregarded and the rational view on organisation becomes conditionally valid.

2.2. Organizations as Natural Systems

Natural system's theory describes the organisation as a social system characterised by the dominant need of survival along with a general desire of goal achievement. The theory explores the behavioural structures of the organisation as these are determinant for the ability of adaptation and survival. The natural organisations, due to their interaction with the outside world and allowance for influences arising from the different structural levels within the organisation, operate in the dynamic internal and external environments and thereby have to deploy a certain level of flexibility in order to self-maintain the system as well as to survive in confrontation with the outside world. It is important for a natural organisation to create an internal balance so that the organisation can be perceived as a robust system by the external actors. A healthy organism has a greater strength and thereby an improved influence-capacity. Therefore an important part of general organisational functions is devoted to self-maintenance activities.

According to natural system's perspective, an organisation is comparable to a living organism that has its own needs to be satisfied in first place. In addition to these self-oriented internal activities, the organisation interacts with the outside world and thereby the external organisations. The organisation is involved in the continuous struggle for survival both on its own functional level as well as on the societal level. This implies that the organisation operates upon several conditions. There is a wide variety of terms employed to describe the phenomenon of conflict of norms conditioning the operations of a given organisation. Scholars distinguish between for instance normative and behavioural structures, stated and real goals of action, formal and informal structures. This rich variety of structures or sets of values not only visualises the numerous needs of both the organisation and its surroundings

but also allows for the conflict of interests and the naturally following processes of adaptation and evolution.

A natural organisation is a living organism capable to change its course of action as well as its' goals. In this view an organisation becomes a decent end in itself. Its' survival is valued more than its' loyalty to formal or informal structure. The survival relies both on defence against the tensions and threats from the outside world as well as on self-maintenance. In other words the success of an organisation depends on defence against any system-overload regardless from its' origin.

> *"Thus, from a means, organisation becomes an end. To the institutions and qualities which at the outset were destined simply to ensure the good working of the party machine (…), a greater importance comes ultimately to be attached to the productivity of the machine. Henceforward the sole preoccupation is to avoid anything which can clog the machinery"*
>
> *Michels, 1949 tr.:390; from W.Richard Scott 1981 tr.:81*

The theory pays a lot of attention to the organisational needs and restrictions on the surrounding environments, but it fails to describe what does the environment itself get in exchange for its' input to the organisation. The model is limited to the systems where the organisation can impose the conditions on the outside world, but does not operate under any external restrictions itself. This is why the natural system cannot be particularly responsive to the environmental changes different than direct disruptions or modifications of input.

2.3. Organizations as Open Systems

The open-system perspective emerges chronologically after the rise of rational and then natural perspectives and it builds on the heritage of both theories. It recognizes the loose correlation between the "individual component parts" (Scott, p.119), as well as the interdependence of the system and its' surroundings. The input from the outside world is perceived as constructive regardless of its' actual content and implications, because it leads to confrontation, reinvestigation, correction and reinvention of the system in a long run. The system remains vital as long as the bond connecting it to the environment is actively used. An organisation interacts with its' surroundings, meaning that it both absorbs the environmental

input and ejects some output to which the environment responds. This interaction stimulates the growth of the system by allowing for both absorbance and ejection of materials. The environment is perceived as enriching rather than menacing, which enhances the dynamics of the interaction process.

The survival of an organisation is dependent upon the ability of processing of the input (either material or informational) from the outside world. The greater the individual processing limitations the higher the probability of organisational defeat. The threat is then not the environment itself, but the limitations of the working-force. Despite this fact, little attention is paid to individuals forming the organisation in the theory of open-systems.

It appears that the open system erases the limitations of a one-way interaction stated by naturalists but it carries on the illusion of obedient individuals smoothly guided by "the invisible hand".

2.4. Searching for a Universal Model, Theory of Contingency and the Environmental Perspective in the Evolution of Organizational Form

Each of the above-described theories of organisation contains both the essentials and the limitations. Both the natural and the open view on organisations appear to describe the organisations exposed to changing environments, while the rational model with its' cold technological facet appears to be custom-made for stable environments. Further, the rational and opened systems can be interpreted as organic, meaning that a living-substance is a fundamental part of the anatomy of the system. This living substance must essentially be understood within the frames of this work as human beings interacting with and within a given organisation. These human beings could either be working in the organisation, being an internal part of it, or interacting with it as an external part. In other words, the organisation has both the internal and the external dynamics to consider.

The environment must then be seen as a critical factor to the choice of organisational model. And if the organisational model can be consciously chosen, then the awareness of the type of organisation's internal and external dynamics is crucial for the decision-maker.

Lawrence and Lorsh (1967) who initially developed the theory of contingency, presumed that organisation's ability to survive is highly correlated to the nature of its' environment and consequently the character of demands imposed on organisation. Some organisations will become more rational as a result of exposure to stable environments, while others will develop natural or open-system's characteristics due to the confrontation with dynamic and unpredictable surroundings. In more complex organisations the phenomenon of exposure to the opposite sets of expectations may also occur across the subunits of the unified system which each can be confronted with different demands simultaneously. This implicates that the deviations from a global organisational form might legitimately occur as a response to constraining environmental demands imposed to the different levels of organisation. This idea is further developed by James D. Thompson (1967) who in his work "Organisations in Action" states that rational, natural and open-system perspectives are all correct but at the different levels of organisation. On the institutional level, the organisation needs to be opened in order to maintain the vital exchange with the outside world, while on the operational level the processes shall be calculated and run as in rational model. The managerial level which lies between the institutional and the operational level bases its' performance on human-relations and negotiations between the open-system's structures and rational structures.

In brief, the organisational form can be variable as it is correlated to the environmental dynamics, or as Scott formulated it:

> *"(…) there is no one best organisational form but several, and their suitability is determined by the extent of the match between the form of the organisation and the demands of the environment"*
>
> *(Scott;1981:p. 125)*

This is how the theory of contingency revalidates the three classical theories of organisation, giving each of them some credit conditioned upon the type of environment the organisation is exposed to in its' performance. We have recognised the human factor as a fundamental substance of external and internal environment of the organisation.

Until now we seem to have focused on two mining-stones underlying the functioning of the organisation:

- the human factor
- the environmental factor

However there is one more core element that needs to be identified in order to pull the theories together and obtain an even more detailed picture of the organisational functioning.
I suggest that we also include a third factor into further analysis:

- the time factor.

2.5. The Hierarchy of Organisations and the Time Perspective

If the organisation responds to changes in environment and the action and reaction processes occur over time then the time dimension is also a decisive factor to the mode of functioning of the given organisation. The more dynamic the surroundings of the organisation, the less time it has to adapt and the more flexible must it become as a system. The more stable the environments (both external and internal), the slower the action and reaction processes. The two extremes on the opposite edges of the modes of organisational functioning are the case of the ever-changing system where no organisational features persist over time, or the never-changing system where the one-sided action is projected but no adaptation ever occurs.

Most of the organisations change over time, like most of the environments evolve or degrade in long run. This hypothesis underlies the statement that any organisation may adapt one of the three classical organisational forms gradually or simultaneously over time in the process of evolution or differentiation of a given organisation.

The time perspective allows us to explore the major dynamic patterns in organisational functioning instead of identifying its' immobile features. An organisation can either change as a unique body over a given period of time, or remain stable. It can also be stable in long run, while it undergoes fragmentised and simultaneous changes within shorter sequences of time.

The major dynamic patterns of organisational functioning could indicate the general life-span tendencies of the organisation, by which I mean the evolution or the extinction of the organisation. In order to differentiate between the evolution and the extinction of organisation, we shall adapt some form of hierarchy of organisations.

I will now introduce the most relevant fragments of the hierarchy of organisations proposed by Boulding. This hierarchy divides organisations in eight major groups, and lists them in ascending order, starting with the less complex systems and ending with the most advanced

models. For the use of this study, I will focus on the first four systems described and set in the following hierarchical order by Boulding:

1. *Frameworks. Systems comprised of static structures such as the arrangements of atoms in a crystal or the anatomy of an animal.*
2. *Clockworks. Simple dynamic systems with predetermined motions such as the clock or the solar system.*
3. *Cybernetic systems. A system capable of self-regulation in terms of some externally prescribed target or criterion, such as thermostat.*
4. *Open systems. A system capable of self-maintenance based on a throughput of resources from its environment, such as a living cell.*

(Boulding, 1956: pp. 200-207)

The list above presents the organisational forms in hierarchical order, starting from the most primitive system and evolving to the more sophisticated systems. Level four is here regarded as the most advanced and thereby desired organizational form. As interpreting the major trends of organisation's functioning, we should identify at which level the organisation has originally started its' existence. Further we need to observe changes over time, and at some point decide to compare the present constellation with the historical constellations. If the organisation evolves it will become steadily more opened. If on the other hand the organisation switches from being opened (or operating at level four of the Boulding's hierarchy) to being closed it might be heading towards its' own extinction. The fragile balance of the ecosystem of the living organisation needs our constant attention, which is why the observation over time remains a single efficient mean of analyse and eventual prevention. This is where the time perspective becomes a decisive factor for the understanding the organisational changes.

It is worth notifying, that the above-described organisational changes over time are a natural part of the organisational life-course, usually leading either to development or degradation, unless the organisation is in some periodical state of stagnation.

2.6. The Theory of Organization of Hypocrisy

Nils Brunsson claims that there exist two main theoretical organisational archetypes. Theoretically organisations can be of either action orientation or political orientation. In both models organisation arrive at different outcomes through the process of talk, decisions and actions. Relations between those three processes might be of various types and will be further explored.

2.6.1. Action-Oriented Organizations

Action model originates from industrial sector, where the main focus of organisations' work is the outcome in form of product or service. Organisation's relation to the environment is exchange-based, and builds on a process where the organisation obtains some part of scarce resources in exchange for the products or services it has to offer to the outside world. It is the product that is the main source of organisation's power because without the product the organisation will not gain the resources needed for its' operating purposes and will thereby not be able to survive. Action organisation uses talk and decisions as ways of attaining coordinated action. Therefore talk, decisions and action are usually consistent and result in the production of a particular product or service. The consistency of these processes guarantees organisation's survival, by assuring consistency of production. This model is the dominant one, therefore most of the members of various organisations would surely identify with it. Producing a material product or measurable set of services, gives visual and clear results. It assures the actors involved in all stages of the production process (from talk through the decisions and to the action) that their efforts are fertile and materialise in physical goods or services that can be identified, measured and even improved.

2.6.2. Political Organizations

The political model describes organisations, which are dependent upon environment in substantially different ways than action organisations. Political organisation focuses mainly on talk and decisions, and both talk and decisions must be considered legitimate products of organisational work. The political organisation intends to embrace constraining demands of

its' environment, erasing in this way the distance between the organisation and the environment and increasing the interdependencies between them. Therefore the more complex is the surrounding environment, the more complicated and inconsistent will be the political organisation's attempts to include environmental voices into its' operating processes.

Talk, decision and action are three separate products of political organisation.

Talk shall be regarded as proof of organisational free- spirit and wide horizons, meaning that it can reflect conflicting external (environmental) and internal (organisational) demands. A reflection of conflicting demands is consequently inconsistent. Therefore talk can be inconsistent.

The "decision" is an attempt of rationalisation of inconsistencies of talk as described above. The decision would often be a selection of a dominant thought or idea, although the argumentation for decision is usually based on "talk" and therefore may be linked to environmental conflicts.

As to action in political organisations, it will not always be the final result of talk or decision. Action may or may not happen, depending on pureness of political system, its' ability to act and last but not least the existence of any environmental constraints that may prohibit the action.

The members of a political organisation are easily dissatisfied with their work, since in most of the cases they do not produce any material outcomes. What they produce is abstract, immeasurable and inconsistent. Although they might have the final voice in a decision-making process, they need not have the power of implementation and therefore their decisions might become fruitless even despite the intentions of the decision-makers.

2.6.3. The Division into Action-Oriented and Political Organizations

In practice, we will seldom manage to divide organizations into pure action organizations and pure political organizations. An overwhelming majority of existing organizations will represent a combination of both theoretical models. Moreover, the percentage of action element contra political element will be most often variable over time depending on both internal and external factors. There will be times for politics and times for action and this variation of organizational profile concerns hospitals as well**.**

2.6.4. The Definition of the Phenomenon of "Organizational Hypocrisy"

The concept of the Organisation of Hypocrisy builds on redefinition of the term "hypocrisy". Traditionally, "hypocrisy" describes a voluntary inconsistency between statements and actions as a fruit of moral rather than pure hazard. Brunsson purifies the term of "hypocrisy" and claims that inconsistencies between talk and action may be involuntary and justifiable as a result of dynamic interaction between the organisation concerned and corresponding variable internal and external environments. As such, the hypocrisy is something rather unavoidable and not necessarily morally dubious (as long as all inconsistencies are not planned). Given the new definition of hypocrisy, we may be better equipped to understand the organisational transformations over time and the fluctuations between action- and policy-oriented models. Secondly, we are given a set of tools for critical assessment for any process of reorganisation. By examining whether the hypocrisy is of traditional or "brunssonian" type, we might uncover whether the organisational change is legitimate or not. Legalisation of hypocrisy as acceptance of inconsistencies between talk and action must be conditioned. Theoretically we can never be certain whether the inconsistencies were planned or whether they appeared as pure reflection of environmental conflict of interests. Secondly, we could probably have higher rates of acceptance for inconsistencies between talk and decisions, or even talk and actions, but lower rates of tolerance for inconsistencies between decisions and actions since decisions appear to be more formal than talk, and actions have often a direct effect on environment. But even this specification of our sensitivity to inconsistencies between talk, decisions and actions will not always be valid. If talk is to reflect and take into consideration conflicting desires of various groups, then inconsistencies between talk and decisions might cause deep dissatisfaction among the groups which interests will not be reflected in the decision. If on the other hand the decision will not be implemented or turned into action, the feeling of betrayal may overcome the tolerance for slighter inconsistencies.

Although hypocrisy as described by Brunsson certainly exists, as the inconsistencies between talk, decisions and actions all do exist, the negative load of the term "hypocrisy" awakens suspicion. The suspicion awoken by the term is useful in the process of critical assessment of the organisational change. Modern organisations truly operate under pressure of conflicting groups and attempt to partly satisfy the upcoming constraining demands. Modern

organisations attempt to listen to everyone and satisfy the few in an elegant way. Talk is therefore a way of proving goodwill and social interest, while decisions are an attempt to run organisation's own business despite the public-will. Hypocrisy of talk and decisions seem therefore to be a conscious process in which the organisation fights for its' own survival. If organisation survives it shall be in the common interest, since it does produce goods and services demanded by the environment. The acceptance of inconsistencies could be therefore morally justified in the name of common interest. Hypocrisy of decisions and actions might be a result of overcoming external power used by ruling authority such as government to influence the course of organisational action by dimensioning it within given legislation or political trend. Any deviation can in this way be morally justified as long as the common interest is the dominant driver of inconsistencies.

2.7. The Relations Between Organizational Politics and Action

Since most of the organisations will maintain some level of both political and action activities simultaneously or over the time, it is important to explore the particularity of relations between politics and action.

Politics is a result of discussion and sometimes its' main product will be the discussion itself, while on other occasions decisions will be produced post to the discussions. Politics can be regarded both as initiator and product of ideas and it evolves in a mental and communicative process. Ideas that can be discussed are literally unlimited, neither in time nor in space. The freedom of thought and the liberty of expression are incarnated in any democratic system and enlarge the organisation's political horizons all the way to the undoable. Organisational politics can describe through a discussion or decision-making ideas that are impossible to implement. It can also include mutually exclusive thoughts without serious difficulties.

Actions on the other side are limited in time and space, and usually two constraining actions cannot be performed simultaneously without serious difficulties. Action is also linked to the present tense and to the current space, meaning that it is either performed right here and right now or non-existent. It has no aspect of past or the future, and in contrast to the thought the action is constrained by physical limitations.

As a consequence of the constraining natures of politics (in terms of ideas and decisions) and actions, the interdependencies between them can normally be loose. Accordingly, the policy makers or the ideologists of a given organisation are usually loosely related to the actors acting on behalf of the same organisation. In extreme cases, where no correlation between ideologists and actors exists, the decisions will have no controllable effect on the actions and vice versa. Despite this general tendency, some correlations between ideas/decisions and actions can be identified and are classifiable into four basic categories (Brunsson 2006): ideas control action, action controls ideas, action and ideas are contradictory (the hypocrisy), action and ideas are uncorrelated. Although the traditional view says that actions are controlled by ideas, in dynamic environments the ideas may in some periods become less dominant over the actions or the other way around. The shifts of the correlation are nothing unusual in organisations of both political and action orientation, as the change and variation lies in the nature of any such organisation.

If the organisation has inconsistent levels of politics and action over time, then the correlations between action and politics will be variable over time. One might think that in the very beginning of a given organisational process politics and action are not correlated at all, since the course of planned action is still not decided and distant in time. This would be the situation of initial discussions or the beginning of a talk stage of the process. As the talk evolves over time, the ideas become clearer and depending upon the democracy of thought present in the organisation, they might either be limited to action drivers or be allowed to freely evolve regardless of any physical constraints present. After a decision has been made, the talk or organisational politics may be reused to justify the decision and to introduce the coming action. Talk post to the decision also serves as an eraser of inconsistencies. Finally at the stage of action, the third correlation may become dominant and lead to modifications of what was decided as well as it may provoke the change of the course of intended action. The possible explanation of this phenomenon is that the talk and the decision-making stages are more independent from the external environments than the action is. The action will have a direct physical effect on the environment concerned and might therefore provoke a reaction in form of protests, demonstrations and even direct prohibition against the intended action. The action has the ability of balancing or misbalancing the coexistence of the organisation and its' environments. Consequently, not all what is decided will actually be possible to put in action. We are not always able to act as we intended to.

2.8. Rational, Natural and Open Systems in Light of the Theory of Hypocrisy

The theory of hypocrisy describes how the organisation handle the dialogue with its' internal and external environments. It focuses on the role of the decision-maker in the process of organisational change. It can be applied to any of the organisational systems, from rational, through natural and opened system, or as Brunsson originally described it, to both action-oriented organisations and political organisations.

As no paradigm is fully descriptive, we should accept that due to the time factor and environmental dynamics, organisations can adapt different profiles at different stages of their life-spans.

Figure 1

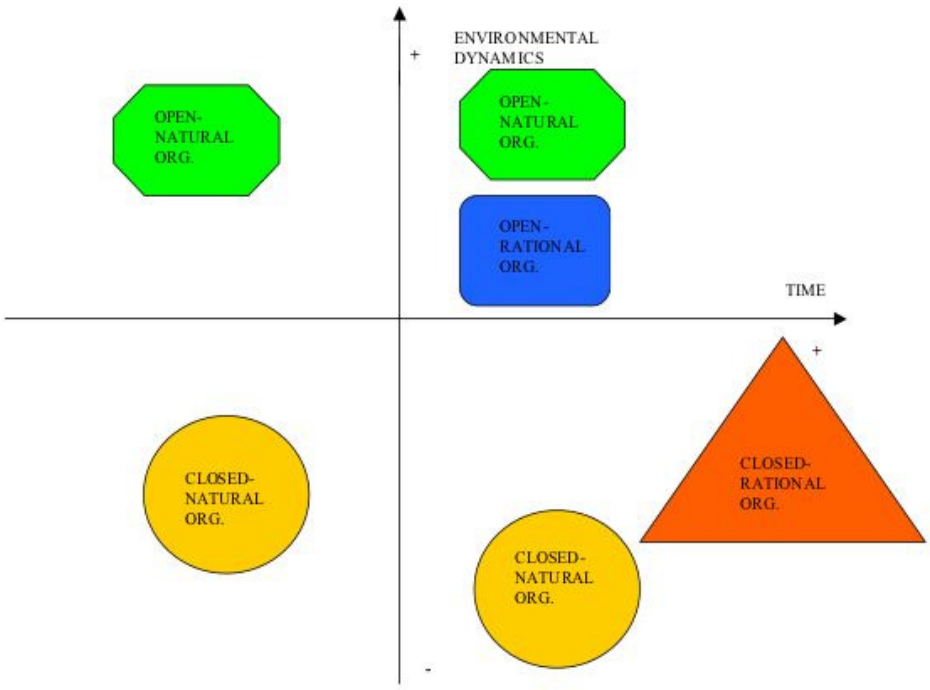


Figure 1 illustrates how the organisational form might change over time, along the time axis and the organisational dynamics' axis. The open natural systems represented by green rectangular figures, are situated in the upper part of the graph, both on the left and the right

hand side. By this, I wished to illustrate that the open-natural system functions best regardless of how much time the organisation has to produce its' output, at the same time the system performs best in highly dynamic environments. The blue figure represents the open rational system that performs optimally in slightly dynamic environments and in situations where the organisation has relatively much time to produce the output. The yellow and orange figures are all situated at the lower part of the graph, referring to the fact that the closed systems (both natural and rational) perform best in stable environments. Although the closed natural systems (represented by yellow circles) can perform both with shorter and longer time limits, the performance is strictly conditioned upon steadiness of the internal and external environments. A closed rational system would function mostly in the stable environments and within a longer time-horizon.

Due to this vitality naturally present throughout the life span of a given organisation, the changes in interaction with both internal and external environments will probably occur. This concerns both political and action-oriented organisations, as at some point of time the organisation will attempt to make a decision and implement it through a physical action in order to produce some visible outcomes. This change in interaction with the environment can be interpreted as a prelude of an upcoming process of a deeper going organisational change, or in other terms reorganisation.

In the beginning of any process of reorganisation, it can be said that that the principle decision-making at most of the times will be undergone at the managerial level of organisation. The managers will limit the number of possible organisational changes and select only a small number of available options to be presented to the internal and external environment. The limitation of the available options reinforces the chances of attaining a collective action leading to a general change once the single option is elected. During the process it is possible that some conflicting demands will arise from the internal and external environments. The management will handle those in various manners, depending upon the stage of organisational existence. If the organisation will be in the stage of rational openness, any feedback from the environment will be elegantly registered but not used in the further process. If on the other hand, the organisation grows towards open natural structure, the surrounding environment will have a visible and measurable influence on the course of organisational evolvement.

It can be also said, that if the organisation develops steady less opened structures over time, it could indicate its' nearby extinction, as with no real allowance for input from the outside world it will not be able to make any solid impact on the environments concerned and the reason of its' existence will vanish.

Last but not least, it is important to identify correctly the involved decision-makers and assign the responsibility for creation of different constraints limiting the number of possible courses of action.

Through observing the "hypocrisy" of the decision makers, the observer shall be able to identify the very first signals of the upcoming organisational change, its' intentions and the stage of a life span of the organisation. If enough of time is allowed for the observation, the researcher could be even able to identify the long-run evolutionary trend of the organisation and hereby predict its' expansion or distinction.

With the above-described theoretical frames, I shall be able to answer the research question and say why exactly Oslo University Hospitals have adopted the recent organisational structure.

3. METHODOLOGY

The choice of methodology reflects the character of the research. It defines the scientific perspective from which the examined problem will be approached. The research question that I defined in Chapter 1, implicates that my research will be based to a great extent on both written and oral sources of qualitative data. The written sources that I have used consist mainly of the documents on the process of reorganization published by OUH. In addition to written documents produced by OUH, I will conduct a semi-structured elite-interviews with the top managers of OUH in order to gain an in-depth insight into the decision-makers' perspectives on reorganization. Moreover, I will also analyze a selection of external documents on reorganization of both OUH and other comparable medical facilities that have undergone similar process of restructuring. In short, the methodology chosen is a qualitative research based on collection, organization and context-specific interpretation of information retrieved both from primary and secondary sources aimed at identifying the inconsistencies between the different managerial levels and stages of the process of restructuration.

3.1. Qualitative research

If we were to define the meaning of "qualitative research" by analysing the significance of the components of the term, "qualitative" and "research", we could probably arrive at some core elements of the generic term of "qualitative research". Term "qualitative" refers to the examined phenomenon and its' specificity and originality visible in details and hallmarks, character and nuances and above all in its' genuine and observable nature (Malterud: 2001). The qualitative tools can be applied for a quality assessment of the examined phenomenon, but in descriptive and not numeric way. The qualitative tools can also refer to norms and values and contrast the quality of the phenomenon examined to those norms and values rather than to the numeric data. Hence the qualitative tools lead to subjective and partly intuitive explanation and understanding of the phenomenon rather than to definitive answers. They promote an open-minded thinking and aim to look for the answers beyond the numbers. They are hence humanistic rather than algebraic and they focus on human experiences, interactions, communication processes, expectations and interpretations (Malterud: 2001). Term "research" implies the dimension of scientific structure and methodology hence introduces the ideas of

consistency, relevance, validity and reflexivity and allows the qualitative dimension of the process gain the legitimacy of the quantitative dimensions present in competing types of research. Then the generic term of "qualitative research" describes the scientific process of anthropocentric research, aimed at analysing and classifying human and societal interdependencies, through methodical analysis of text gathered from primary and secondary sources and by placing the examined phenomenon within normative and value-oriented contextual frames.

I will now explore the standards for a qualitative research and further, examine these standards against the present thesis' generation and structure.

3.1.1. Relevance

The issue of relevance may concern several aspects of the research process. To begin with, we need to examine the relevance of the research question itself and try to judge whether it is sufficiently delimitated and clearly stated. Further, the relevance of the methodology chosen needs to be addressed. We need to define whether we are looking for a concrete and measurable answer provided by quantitative research or rather an explanation for a complex process viewed from an anthropocentric perspective of a qualitative research? Then, we shall assess the relevance of the methods of data collection applied in the study in order to be able to assess the relevance of the results obtained through the study.

In the present thesis, the research question was stated as follows:

Why did Oslo University Hospital adapt its' present organisational model?

I believe that the research question is clearly stated and relevant for the examination of the process of reorganisation of OUS. The question also allows for an intended examination of the inconsistencies that arose at different stages of the process. I aim to provide the readers with better understanding of complex reorganizational process and its' validity based on the way the models of reorganisation were presented, developed and implemented over time. The focus of the thesis will rely on interdependencies between the separate stages of the process and changes in organisational model of OUH. The answer to the research question shall provide the readers with a deeper understanding of the process of restructuration.The

qualitative research is the most suitable methodological approach available to examine the above-described issues.

I gathered the data from the documents internally and externally published by OUH during the process of reorganisation. The documents were published in period from January 1st 2009 until March 31st 2010. I also used the answers to the consultative round initiated by both South-East RHA and OUH delivered by various external actors such as national associations of medical professionals, patients and other groups concerned by the discussed process. Further I conducted six in-depth elite interviews with OUH's management and representatives of the City Council of Oslo. I expect the relevancy of the chosen data sources to be adequate to the research question. I believe that data obtained in above-described way will enhance an objective examination of the process of restructuring of OUH.

3.1.2. The Presentation and the Analysis of the Data

The materials gathered for the purposes of this qualitative research are presented in the chronological order, from the initial frameworks for reorganisation of HAs designed by the State and South-East RHA, through the organisational models considered in the early phase of the internal process run at the OUH, and finally my own interpretation of these models and the presentation of the final model of reorganisation adapted by OUH. Eventually the essential fragments of the interviews with OUH's top management and representatives of the City Council of Oslo are presented in order to both clarify the presented materials and validate my interpretation of these.

The analysis I will use is inspired by an immersion style (Malterud:2001) and builds on thorough examination of text and visual models, and selection of the most important ideas from the available materials. Still, I must admit that I have certainly had tendencies towards template analysis style (theory-based) and the organisation of text although chronological, follows as well the chronology of the applied theoretical frames. I must recognize, that placing my interpretation of the models of reorganisation between the presentation of original models and the presentation of a final model, bridges the two stages of the process in line with the selected theoretical frames.

3.1.3. The Role of the Researcher

Researcher's position and preconceptions must be acknowledged and understood as predetermining for what can be seen in general (Malterud:2001; Haraway 1991). Kristin Malterud has identified several concepts concerned with the researcher conducting a study.

Firstly, a concept of reflexivity, which refers to researcher's attitude of self-investigation aimed at regular identification of the influence of the researcher himself on the research process. This concept is also referred to as "The knower's mirror" (Malterud:2001). In the qualitative studies, the researcher recognises his influence on the study-design and study-conduct and hence confirms his commitment to reflexivity, which in turn enhances the chances for objectivity of the study. The less the role of the researcher is acknowledged, the greater becomes the risk of the rise of subjectivity of the study.

Secondly, a concept of preconceptions, referred to as "The researcher's backpack" (Malterud:2001), which describes the background knowledge and experiences that the researcher brings to the study. Those predetermine the focus, motivation and qualifications for exploring the study, as the researcher is a priori interested in some phenomenon more than in other due to his theoretical and emotional perspectives accumulated throughout a personal and a professional life span.

Thirdly, the theoretical frame of reference, also described as "The analyst's reading glasses", further determines the researcher's approach to the study. The researcher chooses a specific theory and models in order to interpret and qualify given phenomenon.

All the three above described concepts are interdependent. The preconceptions predetermine the frame of reference, and the reflectivity aims to recognise this fact and ensure study's objectivity by a simple statement of researcher's background, expectations and prejudices.

I hereby recognise that at prior to this research I have been exposed to series of influential theories of management, reorganisation, politics and economics throughout my studies at the Institute of Health Management, Politics and Economics at University of Oslo. I have been trained to critically assess all written materials and I certainly used these skills in the present thesis. I have had no emotional connection to the project despite the fact that I have actually been employed at OUH during the process of reorganisation. The office I have been employed at has simply not experienced any major consequences of the entire process, which

presumably allowed me to stay relatively objective. The final decision of the OUH form February the 9th 2010, concerning closing-down of Aker Hospital might have awoken in me some emotional prejudices, since I live nearby the Facility and from January the 1st 2011 I have had to use Akershus Hospital as the local hospital. Nevertheless, my age and good health allow me to ignore this inconvenience due to my low demand for hospital services in general. This means that as researcher I have remained neutral been throughout the process of reorganisation.

3.2. Reliability, Validity and Generalization

Traditionally, the concepts of reliability, validity and generalisation were linked to quantitative research. Nevertheless, in the recent approaches there has been set steadily more focus on those aspects in qualitative research. However the terms of reliability, validity and generalisation take substantially different dimensions in qualitative approach. It is therefore important to readapt the quantitative-oriented definitions to the qualitative-research's settings. After introducing each of the quality-research oriented definitions of the above-listed concepts, I will put them into the context of the present study at the end of each subsection.

3.2.1. Reliability

The concept of reliability in qualitative research builds on the conditions that need to be fulfilled in order for research to be reliable or trustworthy. These conditions apply both to the researcher and to the research. The researcher must be held accountable for the research's direction and evolvement, which is elsewhere described as concepts of reflexivity and preconceptions (Malterud:2001). The conditions associated directly with research methodology, refer to reliability of data gathering techniques, hereby choice of sources and appropriateness and objectivity of analytical methods. All procedures involved must be transparent, understandable and systematic. The researcher shall make a clear distinction between his personal observations and participants' observations. There shall be also a distinction between the information gathered from written sources and this gathered through interviews and conversations. In other words, all the details of the implemented research strategy shall be explicitly stated to enhance the reliability of the qualitative study. Above all,

the researcher shall at every time critically assess his own work and try to eliminate all the effects of subjectivity.

In the context of the present thesis, the reliability is enhanced particularly by the dominance of the original documents published by the AD and board of OUH. Secondly, all the interviews were tape-recorded. I considered conducting the interview in English, but I finally decided not to do so in order to make my Informants more comfortable and allow them to express her ideas in detail not being limited by linguistic constraints arising from the use of a foreign language. My informants were interviewed in her mother tongue, Norwegian, and I was charged with a precise translation from Norwegian to English. I am not a native speaker of Norwegian, but I consider myself fluent user of this language able to distinguish between linguistic details and to ensure the good quality of translation. Nevertheless, there might exist minor inconsistencies between the original transcript and the presented in this thesis translations.

3.2.2. Validity

In quantitative approach, validity is constructed upon reliability. As stated above, in qualitative studies the reliability will depend upon both the researcher and the research methods, but the validity will depend on the interpretation of the data generated through a reliable research process. There exists no concrete method to evaluate study's conclusions validity or authenticity (Chambliss: 2006). Still, singular pieces of information may be contrasted with three major criteria for authenticity (Becker: 1958 from Chambliss: 2006):

Firstly, we should examine how credible were the sources of information. In the context of the present thesis this interrogation concerns the informants and the textual documents. The documents I have used for data retrieval are mainly the original documents published by OUH. Its' authenticity is undoubted and can be easily verified. As it comes to the Informants, I have met them in person for the first time while conducting the interviews. There was also a significant difference of age between me and all of my informants, making the informants quite comfortable and outgoing. Consequently, the statements my informants made in the interviews seem credible, as they were in a comfortably dominant position of a principal attempting to enlighten the actor.

Secondly, the conclusions should be also verified in terms of their explanatory capacity of wider range of global aspects of examined phenomenon, through my ability to interpret both the text and the oral statements in an appropriate context and by accounting for tacit knowledge of the participants of the process.

Thirdly, a comparison to other researches' results conducted in past and examining compatible subjects shall increase the validity of the project. A few relevant research studies conducted on similar issues was shortly presented in the introduction to this thesis.

3.2.3. Generalization

Although most of the research studies are context specific, depending on the transferability and the adaptiveness of the conclusions to other context would often be desirable and referred to as ability of generalisation. I shall present arguments proving the interpretative context applied to a singular study project, has adaptive capacities and can be used for interpretation of other studies. Recognition of my ability to generalise must be seen as a way of prolonging research's vital life by inspiring other researchers to reuse it in their individual projects.

In this thesis I would argue that the discussed phenomenon of the inconsistencies between the discussed, developed and implemented models as well as the reasons for implementation of a particular organisational model can be generalised to other contexts and are of crucial importance to any democratic process of reorganisation.

3.3. The Interview

Interview is a type of oral interaction between the individuals, oriented at a specific issue. Interview is also a research method using the questions as the methodological tools of interaction. Depending on the structure of an interview, the issue that we wish to explore may develop into related issues during the interview or remain as planned in advance. The structure of an interview depends on the nature of investigation, the geographical distribution of the study population and the type of the study population (Kumar: 2005). I will describe the unstructured, structured and semi-structured interviews in this section. I will also justify the choice of the semi-structured interviewing method for the purposes of this thesis.

3.3.1. Unstructured Interviews

The interviews, which allow for free information-flow and evolvement of interview's issue in direction different than initially planned, by allowing the informant to develop his answers into shorter narratives, is called an unstructured interview. In such an interview, the interviewer does not prepare the questions in advance, letting the flexible structure of the interview to take a concrete shape during the conversation with an informant. The questions will appear by no specific order, easily adapting to the issues arising throughout conversation (Kumar: 2005).

The unstructured interviews are especially suitable for elaborating on complex situations, where the interviewer has not a full understanding of the process prior to the interview, and where he learns from the informant about the details of the process as the interview evolves.

3.3.2. Structured Interviews

The interviews, which are structured in advance and which consist of a specific set of questions are structured interviews. Here, the researcher predetermine the questions prior to the interview and put them in a chronological order. In this way the interviewer assures his control over the course of the interview and is sure to explore the aspects that he thought of as most significant to the interview's question. The interviewer must be therefore very well informed on the aspects of the process he aims to examine through the interview, in order to choose the relevant questions. Also, the interviewer must be very accurate in formulation of the questions, since the formulation of the questions prior to the interview demands careful wording and consideration of the effect of question's structure on informant's responses.

The interviewer conducting a structured interview is non-responsive to informants' answers, in the sense that the answers cannot inspire any new questions or areas of interest to the study.

Structured interviews are particularly suitable for series of interviews, where the interviewer conducts the same interview individually with members of a given focus group. The rigid interview structure guarantees that each informant will be confronted with identical questions and thereby will provide his view on the identical matters. This will make the individual interviews comparable.

3.3.3. Semi-Structured Interviews

Semi-structured interviews combine different elements of structured and unstructured interviews, allowing for different levels of specificity and flexibility (Kumar: 2005). The interviewer prepares a draft with main questions that he would like the informant to elaborate on. Simultaneously, the interviewer accounts for dynamics of the interaction with the informant and is prepared to ask unstructured questions as the informant initiates unpredicted though relevant course of discussion.

A semi-structured interview seems suitable for interviewers that wish to examine concrete aspects of an examined situation and that account for inequality of information between himself and the informant. It is also an appropriate research method in case where the interviewer has no wide expertise on interviewing and wants to make sure that the course of the interview will be partly under his control.

For the purposes of the present thesis I will conduct semi-structured interviews because of the following: I am not an experienced interviewer and my informants are all in high managerial positions. I cannot assess whether they will attempt to take control over the course of the interviews, which is why I wish to construct some pillars for our interaction. By preparing some major questions I am hoping to inspire my informants to develop their answers into longer narrative passages allowing me to gain a deeper understanding of the complex process of reorganisation of OUH and conducting me at the aspects of the process that I have not thought of before. I shall then be able to ask further questions on the emerging issues of interest to the study.

3.3.4. The Informants

All of my informants belonged to the top managerial level of Oslo Univeristy Hospital. They agreed to be referred to by using their full names and positions. I interviewed four women and two men, in total six informants. I spoke to each of my informants for about 30-40 minutes. I will use some of the information gathered from my informants in *Chapter five* of this thesis.

4. THE HISTORICAL BACKGROUND AND PREMISES FOR THE PROCESS OF REORGANIZATION OF OSLO UNIVERSITY HOSPITAL

An international trend for restructuring of organisations and institutions expresses an attempt to achieve cost-control and quality improvements through the structural changes. Both national and transnational corporations seem not only gain more structural power but they are said to profit from the advantages of economies of scale achieved through the mergers (Bull and McNeill, 2007). Health sector has not been resistant to these fusionative tendencies either. Mergers of hospitals have been thought of as a way of achieving similar benefits of economies of scale and allowing both for significant cost-reductions as well as quality improvements in health services. Hence the ideas of restructuration inspired by industrial sector are experimentally applied to health care sectors' settings with various effects. The experiment might be seen as an attempt to infiltrate health care sector with the outsiders and their industrial perspectives. This attempt is also a desperate step towards establishment of cost-control tools particularly difficult to develop and implement in health care sector traditionally managed by clinical leaders. It is as well a way to destabilise the rigid hospital hierarchy and to remodel it to fit the dynamics of present economical and societal situation with its' contradictory demands. This chapter explores an initial selection of organisational model for South-East RHA as well as Oslo University Hospital at the stage of organisational talk and decisions. It opens by identifying the three organisational levels: institutional, managerial and operational. Further, it explores the guidelines for reorganisation signalised by the Parliament to the Regional Health Authority and presents further a signals forwarded by South-East RHA to OUH. Eventually the Chapter describes an interpretation of these signals made by OUH's Administrative Director, Siri Hatlen and presented in form of three alternative models of organisation of OUH.

4.1. Identifying the Institutional, Managerial and Operational Levels in the Process of Reorganization of OUH

James D. Thompson (1967) distinguished between the different levels of organisations. The highest organisational level is the institutional one. Here, the organisation is mostly open and

produces universal decisions that have the potential of being generally implementable. The managerial level is the one that links the universal decision-maker with the actor that develops and implements the decision into the real life. On this level of organisation, further decisions will be made through the process of negotiations. The operational level of an organisation is the one that seeks for implementation of the decisions made by institution and reinforced by management.

The institution of public secondary health care services in Norway might be interpreted as unified body consisting of the following three levels: the institutional level in form of the State, the managerial level present in RHA structure and the operational level of the underlying HAs. Although one could have chosen to look at the above specified three organisational levels as separate bodies, I decided to treat them as the organisational levels of one single institution - the institution of publish secondary health care services.

The Norwegian State has been the owner of all public hospitals since the implementation of the Hospital Reform of 2002. The State has an institutional power towards secondary public health care services provided in Norway. Through the establishment of RHAs the State has created a managerial level capable of producing individual decisive and financial outcomes and aimed and controlling the underlying operational level in form of HAs. HAs produce measurable outcomes in form of improved public health, in line with the institutional expectations and managerial guidelines.

4.2. Organizational Tendencies at the Institutional and Managerial Level of Public Secondary Health Care Services

4.2.1. The General Effects of the Hospital Reform of 2002

The Hospital Reform of 2002 was meant to give a wide spectre of organisational opportunities to all of the RHAs. However the RHAs have mainly chosen a very similar operational model consisting of fusions of HAs based on geographical principle, and resulting in tighter RHAs' control over underlying HAs. These particular organisational tendency is rather inconsistent with the incentives for free-market and open competition among HAs created by the Reform.

While the tendencies emerging after the Reform can be interpreted within the New Public Management's (NPM) theory, according to which the efficiency of the organisational model relies on contractual management, free-market competition and professional leadership dominating over owner's leadership, their adverse interpretation made by RHAs falls within another more conservative trend present in reorganizational models of public institutions, which is called a corporate model (Nerland, 2007). The corporate model builds on the theory of economies of scale and in RHAs' interpretation of that theory the model implies series of vertical fusions along with centralisation of highly specialised functions and general administrative integration. In general, the RHAs' argumentation against free-market competition was based on the fact that the great majority of HAs were geographically spread to such an extent, that they might have been assumed to be in a quasi-monopolistic position and therefore remain inelastic to incentives created by a free-market competition. On the other hand, centralisation of some of the treatments' functions could lead to the economies of scale in form of centralisation of resources used on technical equipment and specialised medical staff. The other advantage of corporate model was the increased quality of treatment achieved through "learning by doing", where the particular HA attained an advanced level of skills in performance of a given treatment, due to high number of treated patients.

4.2.2. The Fusion and Further Development of Health South and Health East RHAs

Six years after the implementation of the Hospital Reform of 2002. In the *Proposition to the Storting (Parliament) no. 44* (2006-2007), the fusion of South and East RHAs was proposed. The Storting decided to fusionate the two RHAs into South-East RHA. The following tasks were assigned to the merged RHA:

- *to improve coordination in the area of Oslo*
- *to coordinate the medical science*
- *to achieve economical improvements through the economies of scale*
- *to further assure the decentralised health care services*
- *to better coordinate and use the human resources, surfaces, ICT, facilities, investments etc.*

(St.prp.nr.44 (2006-2007))

The merged South-East RHA followed the same corporate tendencies as the remaining RHAs, despite the fact that it's geographical territory and market position of subordinated HAs differed importantly from HAs belonging to other Regions.

The core of the above-stated differences concerns in particular the case of the city of Oslo, in terms of population density drastically higher than in the other parts of Norway. The population density in the County of Oslo was 2.858 inhabitants per square kilometre in 1999 (Gjennomsnittlig befolkningstetthet i tettsteds-arealet til Stor-Oslo tettsted, etter kommuner,1999*SSB). As a matter of fact, based on that demographic data as well as on the geographical localisation of the three discussed hospitals, which all are situated within a city of Oslo, the implementation of a free-market competition shall be considered an appropriate alternative for organisation of OUH. However, the pre-existing functions' division among the three Hospitals (Rikshospitalet specialised in advanced medical treatment of cancers and seldom illnesses, Ullevål Hospital specialised in emergency and trauma treatment and Aker Hospital had a pure local hospital function) navigated the reorganizational process into the direction of corporate model and not free-market/NPM model. The competition among these three Hospitals has literally never existed, while the functions' sharing has been implemented since the period of County ownership of Hospitals prior to the Hospital Reform of 2002. Already at that time, the Hospitals were specialised in a specific field of treatment and as I will shortly present, this fact was a strategic milestone used by South-East RHA in its choice of corporate model and rejection of NPM model building on free-market competition and contractual management.

4.3. The Consultative Round on the Merger of University Hospitals of Oslo and the Capital City Process

On June the 20th 2008 South-East RHA sent out a note on *Reorganisation programme- Input Area 1- The Capital City Process* for a consultative round to all relevant actors such as the City Councils, the County Governors, RHs, RHAs, patients' organisations etc. The note contained a brief description of two organisational models that South-East RHA wished to be consulted on. The first model featured gathering of national and regional somatic functions, achieved through a merger of Ullevål Hospital and Rikshospitalet. Additionally, the merged Hospitals were to be charged with responsibility for some of the local hospital functions for

the area of the city centre of Oslo. Aker University Hospital along with two private hospitals (Lovisenberg and Diakonhjemmet) would be in charge of local hospital functions for the remaining areas of Oslo. Model no. 2 assigned the responsibility for the local hospital functions for the area of the city centre of Oslo as well as the multitrauma care functions and some regional functions to the Ullevål Hospital. Rikshospitalet was to be charged with the national hospital functions and most of the regional hospital functions. Aker Hospital as described in model no. 2, would be in charge of detox and psychiatric treatment. The purpose of the initiated by RHA consultative round was to obtain concrete answers concerning the choice of the preferred model, as well as to gather answers to 10 questions listed in the separate attachment. One of the questions opened for the suggestions concerning alternative organisational models.

All of the hospitals of the city of Oslo have delivered their comments during the consultative round. Moreover, they all have chosen model no. 1 as the preferred one, although with some individual suggestions.

Aker University Hospital pointed at model no. 1 as the preferred one and further suggested the organisation of the three hospitals into two separate RHs, one of which with the responsibility for multitrauma care and regional functions and a separate one charged with local functions and most of the area functions. Aker wished to promote the concept of local hospital under the label of "City hospital".

Rikshospitalet chose model no.1 arguing for stronger gathering of national, regional and area hospital functions within one single RH mostly located in the area of Gaustad. Rikshospitalet also expressed a need for reinforcement of the institution of local hospital in Oslo additionally charged with some area tasks.

Ullevål Hospital also gave its' support to model no. 1, however with some important adjustments. The Hospital recommended the fusion of the three RHs. This merger could be named Oslo University Hospital. The Hospital supported the principle for gathering of surgical emergency functions as well as the local emergency functions. At the same time it also pointed at the fact that the reduction of the catchment area resulted in patient basis which appeared too narrow for as many as 3 hospitals.

Another important feedback that emerged during the consultative round, was the one presented by the City Council of Oslo in the end of October 2008. The feedback was not only

based on the Councils expertise, but also on the feedback from 13 urban districts. One of the important moments of the Council's feedback, was the suggestion of development of Aker Hospital into a modern "City Hospital". In principle, the City Council was against a creation of single RH in Oslo, due to the risk of negative influence on local hospital's independence and thereby a limitation of its' capacity to provide the population with adequate health care services.

In light of this suggestion and based on solid expertise emerging from a wide consultative round in period June-October 2008, it was preferable to merge Rikshospitalet and Ullevål Hospital and charge them with the heaviest national, regional and area functions, while delegating the responsibility for the local health care services and some area functions to Aker hospital that was to remain a separate RH.

However, South-East RHA recommended in its' final decision of November the 20th 2008 to use the organisational model no. 1 as interpreted by Ullevål Hospital, implying the fusion of all of the public hospitals of the city of Oslo. The new RH structure was to be named Oslo University Hospital (OUH).

4.4. The Goals of the Capital City Process

As we have seen in the previous section, South-East RHA chose a particular organisational strategy. The goals of the organisational restructuration were described in several cases of RHA's Board Assemblies, for instance in Board's case no. 068/2007 *The general program of development and restructuring Of Health South East (Samlet program for utvikling og omstilling av Helse Sør-Øst).* The *Programme* focused on the following aspects of health services provided by the RHA:

- *effectiveness (measured by concrete health gains)*
- *security and safety (the erroneous events are to be avoided)*
- *users' involvement*
- *coordination and continuity*
- *satisfactory resource consumption*
- *availability*

(Health South East Board Case no.068/2007)

Further, in Board's case no.038/2008 it was said that the goal of the restructuring of South-East RHA was to meet the patients' needs now and in the future. Elements of the above mentioned Board's cases also became an important part of the Strategic Plan for the Development of South-East RHA 2009-2020.

The general principles for further development of South-East RHA were closer described in Board's case no.138/2008:

> "*The future organisation and priorities will assure an improved equality and accessibility to the health services in the Region. The RHA intends to achieve less variation in services provided and resources consumed in the underlying HAs as well as a more decentralised supply chain of services.*
>
> *To guarantee quality of services in South-East RHA, the most specialised services are to be assembled and centralised while the most common services are to be decentralised. The local based specialised health services are to be easily accessible. Sufficient intake plans and patient volumes will be established in order to guarantee a high quality specialised health services.*
>
> *A greater focus is to be paid to the continuity of patients' flow. The definition and development of patients' flow will be a decisive factor to the dimensioning and organising of the different healthcare services".*
>
> (South-East RHA Board's Case no.138/2008)

The Capital City Process (*Hovedstadsprosessen*) as a part of the general reorganisation process of South-East RHA was discussed in detail in the same Board Assembly of November the 20th 2008.

Firstly, the RHA decided to redefine its' original division into health plans and adapt it to the new hospital areas. A particularly important element here was the construction and dimensioning of new Akershus University Hospital. This newest HA was to serve the population of 3 districts of the city of Oslo (Grorud, Alna and Stovner), the county of Rømskog and the Region of Akershus (with the exception of counties of Bærum and Asker). The population basis transferred from Oslo and assigned to Akerhus University Hospital was of over 160 000 people. Secondly, it was decided that from the January the 1st 2009 Oslo University Hospital will be established and will consist of fusion of the following HAs: Rikshospitalet, Ullevål University Hospital and Aker University Hospital. The Board of South-East RHA further described the organisation and development of OUH. The main

requirement towards the fusion of the public hospitals of the city of Oslo was to reinforce the distinction between the local and national or regional specialised health care services.

The local specialised health services shall be equally provided to the population of the city of Oslo. The OUH would enter a project of collaboration with the City Council of Oslo during 2009. This project was aimed at exploring together the new organisational forms in order to provide the satisfactory health care services to the multiethnic groups of patients and to reduce social inequality. It was also mentioned, that two private hospitals; Diakonhjemmet Hospital AS and Lovisenberg Hospital AS would continue to provide the specialised health care services in accordance with contractual agreements with OUH. Finally, the Board signalised that the areas and other facilities used for the purposes of local specialised health services should be reduced in accordance with the reduction of the population's basis.

The national and regional specialised health services which have existed simultaneously in different localisations were to be assembled at Rikshospitalet. The arguments underlying this particular decision build mainly around the necessity of establishing a single national hospital serving as a reference for the foreign nations, gathering together the highly specialised medical staff and reinforcing the scientific environment. The new buildings and facilities were planned to be used and should be further explored by OUH. The Board of South-East RHA expected that the fusion of HAs of Oslo would lead to an ameliorated organisation and thereby give an improved economic potential, which again would allow for the investments in national/regional hospital localised at Gaustad (Rikshospitalet).

4.5. The Choice of Organisational Model at the Operational Level of the Process

According to Administrative Director (AD) of OUH, Siri Hatlen, the two major premises of successful fusion of Aker Hospital HA, Ullevål University Hospital HA, Rikshospitalet into OUH, were firstly the maintenance of efficient patients' flows and secondly the creation of clear organisational boundaries between the local hospital's functions and the national/regional hospital's functions (leader meeting at Ullevål Hospital, 2 Jun, 2009). Siri Hatlen considered three organisational models, each of which built on integration of functions and thereby partly limited the scope of competition among the three Hospitals.

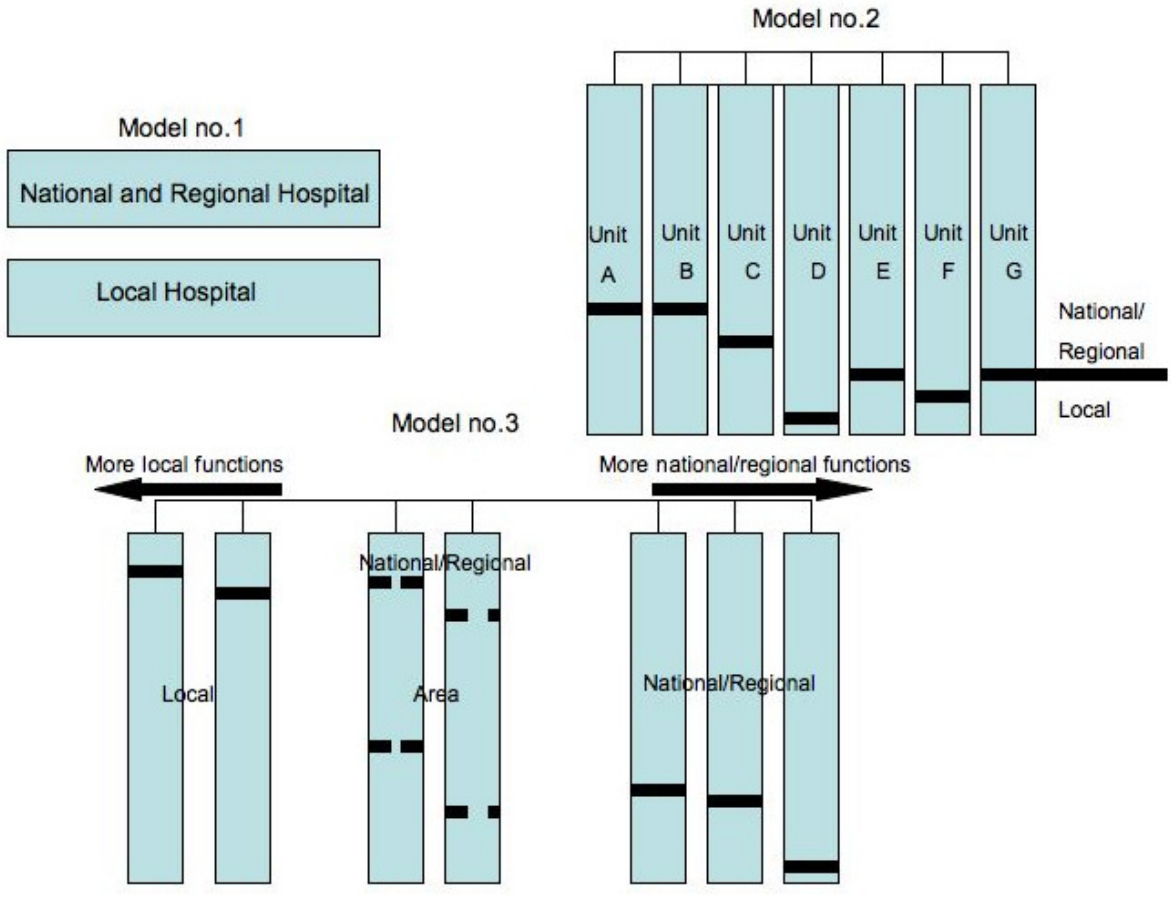
The diagram below is the English interpretation of the original diagram presented by AD, Siri Hatlen, at the leader meeting of June the 2nd 2009 at Ullevål Hospital. The AD's explanation of this model is as follows.

Model no. 1 illustrates a straightforward division between hospital's local functions and national/regional or area-functions (NRA functions) at secondary health care level (level 2). The specialist environments are allocated in line with the allocation of treatment functions available at this level.

Model no. 2 presents an organisational concept where no differentiation between hospital's local and NRA functions is made at level 2. The specialists' environments are gathered across the various levels of functions (from local and through NRA).

Model no. 3 is a combination of model no. 1 and no. 2. The differentiation between local and NRA functions is slightly sharper; however merging of the specialist environments is not absolute.

Figure 2



The MD constructed her normative basis for choice of the organisational model upon following eight premises:

1. Patients' flow shall be logical and effective, as well as giving the patients an experience of "door-in" service.
2. Managerial lines shall lead to clarification of accountability, and model's complexity shall result in logical merging of activities in each organisational unit.
3. Growth of provided services could be either directed towards clarification of hospital's local functions and strengthening of research, or strengthening of fields of highly specialised medicine (NRA level) and innovation.
4. The organisational model shall give support to division between local and NRA functions, as well as provide equal medical services to all patients' groups.
5. The model shall facilitate the interaction between the Hospital and its' external partners such as the Council of Oslo, other hospitals and the University.
6. *LEON principle (lowest effective level of care)* shall be reflected in the chosen organisational model, guaranteeing the patients an appropriate treatment.
7. The model's implementation shall be of acceptable risks' level.
8. The chosen model shall support profit-maximizing and improvement of efficiency of resource allocation.

Based on those premises, the MD, Siri Hatlen chose to implement the organisational model no. 3. According to her, this specific model allows for input from specialist environments and represents a compromise between contradictory interests. Thereby it shall give the lowest implementation-related risk-rates. Moreover it introduces sharper boundaries between different functional levels and therefore supports the *LEON* principle.

5. ANALYSIS AND DISCUSSION

In this chapter I will confront the major theoretical models describing the organisation that I introduced in Chapter two with the information concerning the process of reorganisation of OUH gathered from written sources as well as the interviews with the managerial elite of the Hospital and the Chief of Health Unit at the City Council of Oslo.

I will rely on the theory of contingency as presented by James D. Thompson (1967) and assume that different organisational archetypes can be found at different organisational levels and during different stages of the process of restructuration. However I will be mainly interested in verifying whether the general premises expressed in a stage of talk at operational level of organisation(OUH) are in line with the principle frames provided by both the institutional and managerial levels (the State and the RHA). The analyses of the evolution of the organisational model will be limited to the operational level of the organisation, hence to the model developed by the management of the OUH.

Therefore, I will open this chapter by recalling the premises given by the three levels of the organisation, namely by the institutional, managerial and operational levels. The premises will be reassembled in form of a table in order to facilitate the comparison. It shall be crucial to verify whether the principles developed on the operational level refer to the premises created by the managerial and institutional levels.

Further analysis will focus on determining the character of the operational level of the process at the different stages of restructuration. It shall be achieved through describing OUH in terms of rational, natural, open or closed system in accordance with its' organisational characteristics detectable at a given time.

I will hence focus on the organisational choices of OUH and analyse the graphical models of restructuration initially presented by Siri Hatlen. I will deliberate what factors might have contributed to both choice and evolution of the given models. This part of analysis shall help determine whether OUH at its' early existential stage was a rational or a natural system. If OUH manifested tendencies towards rational organisation, the presented options of restructuration were purposely limited and aimed at operationalization By paying close attention to the responsiveness of the central management of the Hospital to the internal and

external influences during the process of reorganisation, I shall be able to say whether OUS at its' early stage of existence was a closed or an open system.

The above-described analysis shall provide me with a solid fundament needed to answer the following research question:

"Why did Oslo University Hospital choose the actual organisation model?"

5.1. The Comparison of Premises for Reorganization of OUH Provided by the Three Organizational Levels

In *Chapter 4* of this thesis I have described in detail the principles for the process of restructuration provided by the State, further developed by the South-East RHA and locally adapted by the OUH. As we will shortly see, the principles created at the institutional level of the organisation are of more general character, while the ones described at RHA and OUH level are more detailed and adapted to the local expectations. The table below reassumes the institutional, managerial and operational principles that I referred to in *Chapter 4*.

Table 1

The Premises for the Process of Restructuration of OUH		
The State	**South-East RHA**	**OUH**
1. The general coordination in the area of Oslo.		
a) To improve coordination in the area of Oslo	*a) Coordination and continuity*	*a) Facilitated interaction between OUH and its' external partners such as the City Council and other hospitals.*
2. The coordination of the specialized medicine.		
a) To coordinate the medical research.	*a) Centralisation of specialised services*	*a) A development of specialised medicine.*
3. The coordination of human resources, facilities and patient flows.		
a) To better coordinate and use the human resources, surfaces, ICT, facilities, investments etc.	*a) Coordination and continuity*	*a) Logical merging of activities.* *b) Logical and effective patients' flows.* *c) Lowest effective level of care.*
4. The economical improvements.		

a) To achieve the economical improvements through the economies of scale	*a) Satisfactory resource consumption* *b) Effectiveness (measured by concrete health gains*	*a) Profit maximizing and improvements of resource allocation.*
5. The Centralization and decentralization of health care services.		
a) To further assure the decentralised health care services	*a) Centralisation of specialised services and decentralisation of the most common services* *b) Separation of local hospital's function from national/regional functions*	*b) A distinction between the local and national/regional hospital's functions.*
6. Accessibility, equality and availability for patients.		
a) To further assure the decentralised health care services	*a) Improved equality and accessibility* *b) Availability*	*a) Accessibility and equality of services for different groups of patients.*
7. Patient's safety and involvement.		
	a) Security and safety (the erroneous events are to be avoided) *b) Improved users' involvement*	
8. Accountability.		
		a) Clarification of accountability through improved managerial lines.

(St.prp.nr.44 (2006-2007), South East RHA Board's Case no.068/2007 and 138/2008, Overordnet organisering i Oslo universitetssykehus HF (4 Jun, 2009))

I clustered the different premises into eight focus groups. As we can clearly see, most of the stated principles reappear throughout the three organisational levels. Although the wording might be slightly different in some cases, the general impression is the one of the consistency between the institutional frames for the process of restructuration and the two underlying administrational levels, namely the South-East RHA and OUH.

The core differences appear meanwhile under point 5, *The Centralization and decentralization of health care services.* The State wished to maintain some level of decentralisation in secondary health care services, while the RHA expressed the wish for centralization of the most specialised services (the national and regional) and the decentralization of the most common (the local) services. More specifically for the case of OUH, the RHA gave signals to clearly separate the local services from the national/regional services. Siri Hatlen interpreted the recommendation for a separation of the different levels of

secondary health care services as the urge to distinct them from one another. A term "distinction" in contrast to a term "separation" does not necessarily imply a physical disjunction. We will come back to this issue and take a closer look at the consequences that this reformulation of premises implies in section 5.2. that analyses the organisational models initially evaluated by OUH.

Another important difference relies on the issue of *Patients' security and involvement* specified among other premises by the RHA but omitted by the underlying administrational level of OUH at least in the early stage of the process (leader meeting at Ullevål Hospital, 2 Jun, 2009). However, while I interviewed Eva Bjørstad who was in charge of Patients' safety and general system quality in OUH, I have learned the following about the patients' safety systems:

> *"The issue of patients' safety has been taken care of (…) through the maintenance of a system where all (…) erroneous events are being registered. We would not have ended up with the organisation we have today if we had not used this system already from January the 1st 2010 (…). Before, each hospital used to have its' own system, but now in the first phase, we have four fully operative patients' safety systems. In addition there is a great focus on integration of these four systems, so that we as soon as possible establish one single administrative system with common waiting-lists (…)"*

As we can see, despite the fact that the issue of patients' safety was not initially listed among the premises for the restructuration of OUH presented by Siri Hatlen in June 2009, the issue itself was handled during the later stages of the process. One might argue that if the issue of patients' safety was visualised among the list of premises from the very beginning of the process, the system immaturity in the starting phase of merger could have been avoided. Eva Bjørstad stated later on in the interview that there were however no indications of reduced patients' safety after the implementation of the hospitals' merger.

As it comes to the patients' involvement in the process of restructuration, the issue was omitted at OUH level during the meeting of June 2009 where Siri Hatlen presented the premises for restructuration listed in the table above. Through my interviews I captured the signals implying that there existed some level of uncertainty concerning the extent to which the patients might have influenced the process. Nevertheless there was no doubt that several channels were opened for patients' voices. Among these my interviewees mentioned the initiation of several large consultative rounds and working-groups involving the

representatives of the patients. These channels have been used throughout the process. Eva Bjørstad described in detail how the patients might have influenced the restructuration of OUH, pointing at the Patients' Council that has taken part in all projects of organisational development as an important channel for the exercise of patients' influence. However Tove Strand, the vice administrative director of OUH expressed the following concerning the patients' involvement in the process of reorganisation:

> *"We have conducted a large consultative round. But it was first and foremost us who were placed within the Hospital that had to deliberate how to use the social resources in a best possible way (…). Because it does not really matter for a patient how we have organised ourselves given that the patient-flows are continuous and well-functioning. And the quality of the services must be good. So this is first and foremost a problem that concerns our resource consumption, in terms of human, financial and areal resources, we must do it in an effective manner".*

The above reasoning conditions the correctness of the possibly reduced influence of the patients on the process upon the outcomes of the restructuration in form of undisrupted and functional patient-flows as well as the health services of the good quality. In light of this reasoning the accountability for both the grandeur of the consumed resources and for the outcome produced relies on the decision maker or more precisely on the internal management of the OUH and not the external parts regardless of the grade of involvement in the entire process.

5.2. The Analysis of the Organizational Models Employed

As briefly mentioned in previous section, one of the crucial discrepancies between the premises given for the process of reorganisation of OUH relies on the rephrasing of RHA's demand for separation of local and national/regional functions into the differentiation of the functions. I will explore how this reformulated principle was included into further stages of the process at the operational level of the organisation.

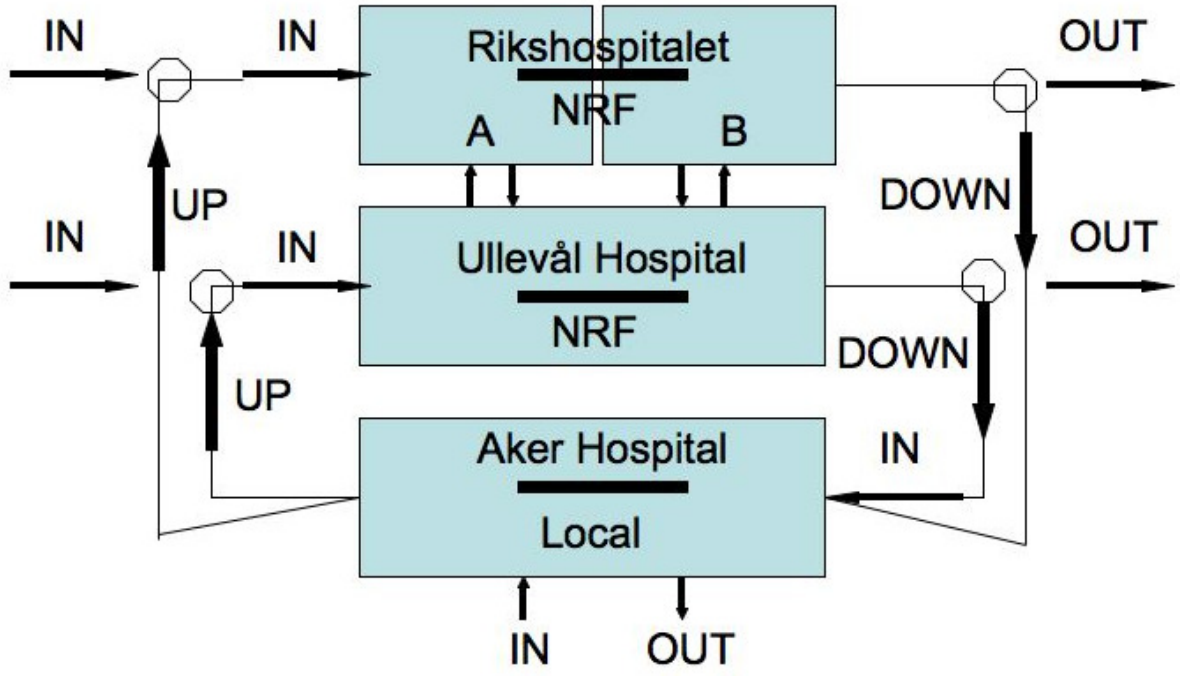
5.2.1. Rebuilding of the Organizational Models Proposed by Administrative Director of OUH Siri Hatlen

The organisational models proposed by AD Siri Hatlen shall be regarded as simplified sketches that were drawn based on the assumption that the audience presented with these has a common understanding of the process of reorganisation as such. However some serious misunderstandings might arise from this presumable assumption. The initially presented models attempt to represent a complex process of reorganisation and are therefore particularly sensitive to any oversimplification. Attempts to simplify graphical presentations of complex processes might be interpreted by the audience involved as an attempt to mask some important facts. The possibility of this unfortunate outcome is serious enough to inspire a thorough rethinking of any graphical presentations of organisational models. Moreover, the audience observing the processes of reorganisation of OUH consists not only of internal and external experts, but as well of inhabitants of the city of Oslo. They all have varying background, and this shall be taken into consideration while presenting the models of intended organisational changes.

For the above-mentioned reasons as well as the purposes of the present analysis we shall gain a more in-depth insight into the proposed models. The analysis of the three models discussed by Hatlen will be further divided into two parts. Firstly, I shall restructure each of the models and adopt it to the physically existing following hospital units: Ullevål Hospital, Aker Hospital and Rikshospitalet (unit A and B- representing consequently Rikshospitalet and Radiumhospitalet). Secondly I shall fulfil them by presenting a final model not initially presented by Hatlen but inspired by her later decision concerning Aker Hospital. This model will be placed at the end of this part of my dissertation being a logical extension of the initially discussed organisational models and enabling us to contrast the stage of organisational talk with the stage of decision-making.

Model no.1 presents a physical division between local and national/regional functions (NRF). Since we physically have 4 separate hospital units, I suggest the following visualisation of the concept (Figure 3).

Figure 3

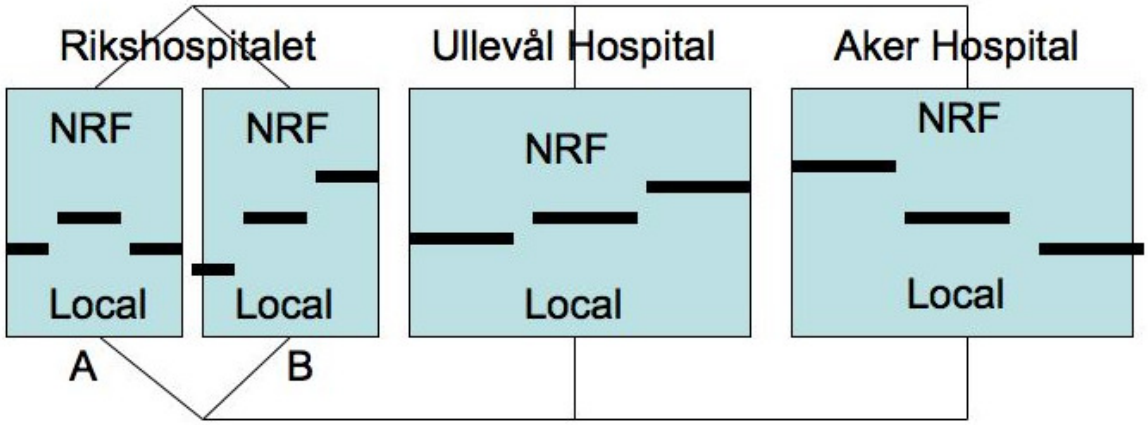


Firstly, the structure is maintained vertical, in order to reflect the hierarchy of the disconnected Hospitals according to their level of specialisation and size. Consequently, at the bottom of Figure 3 we can see Aker Hospital that maintains its' function as a local hospital and gradually overtakes the parts of similar functions from the coexisting hospital complexes. This hospital is providing the basic level of specialised health care to local patients and in this way provides a clear basis for application of LEON principle. Ullevål Hospital and Rikshospitalet are placed in the middle and upper part of the model, representing the higher specialisation of treatments and consequently national-regional hospitals' functions and volumes. The coexistence of two highly specialised hospitals within a relatively small geographic area is not an innovation as such, since both Hospitals have already functioned side-by-side. Each of them has specialised on different treatments. In this way these two units became complementary rather than competing. The innovative aspect of the proposed model is a strict separation of local and NR-hospital's functions. This appears to be an implementable project, since the local function is the easiest to move around and be fully assembled in Aker Hospital. At the same time, both Rikshospitalet and Ullevål Hospital have some well-established facilities needed for NR-functions. Separating local patients from the remaining patients will free up additional capacity at a relatively low implementation cost. On the other hand, if we take a closer look at patient flow represented by arrows pointed in four

directions (UP, DOWN, IN, OUT) we might realise that the model does not represent a closed circuit. Although the patients can be sent up from the bottom-line Hospital, as well as graded down again, the patient flow between the two upper Hospitals seem easier than upgrading the patients upward in the system. Additionally the higher specialised Hospitals are in power to send the patients down the system at any convenience without a greater effort. This might result both in desirable maintenance of patients at lowest effective level of care, as well as in unnecessary discontinuity of care through premature downgrading of the patients from more specialised units to the initial local hospital.

Model no. 2 (Figure 4) represents the concept of three highly specialised Hospitals that despite the fact that they maintain the base-line local function have no sharp boundaries between local and NRFs at a certain level of health care services. I suggest the following visualisation of this concept.

Figure 4

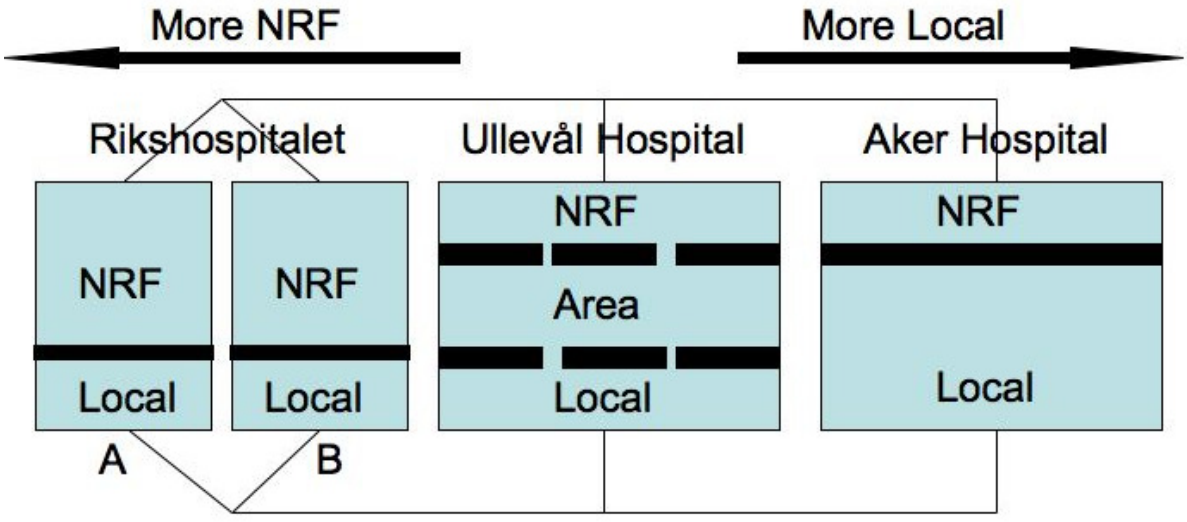


This model opens for fairly significant level of flexibility in particular for medical professionals' environments, enabling to adopt the level of the treatment to individual patient's needs by freeing-up the available resources in one particular unit and transferring them to the unit with scarce resources. It does allow a greater responsiveness to the patient flow by transferring Hospital's human and other resources rather than patients. Theoretically patient focused care shall be an optimal mode since the patient is the genuine purpose of Hospital's existence. Nevertheless, the level of flexibility built in the above-illustrated model represents a serious managerial challenge and might lead to unintended chaos and severe inefficiencies. On the one hand, the continuity of care, the maintenance of the patient at the

lowest-possible level of care and some resource-reallocation gains could be enhanced by this organisational structure. While on the other hand a focus on a single patient or smaller patients' groups might easily lead to inequalities of access to the health care services, in availability and inefficiency. In other words, the elimination of physical boundaries between NR and local functions threatens the pureness of the macro-vision of Hospitals' operating tasks by conditioning it upon constantly changing in volume and complexity patient flow. A solution to this problem might be to define some of the boundaries of central units and to stabilize the internal structure and level of activities. A fixation of the boundaries could be achieved through partial binding of the medical professionals to certain groups of patients and allowing only the highest specialised professionals to function across the NR- and local functions. It is worth to notice, that another outcome of an instable hospital environment implied in model 2, is the necessity of cooperation with coexisting Hospitals, mainly in means of patient reallocation across the Hospitals. What was then intended to be a patient focused system could at some point of time become a crisis-driven complex unable to take care of both NR and local patients simultaneously.

Model no. 3 (Figure 5) represents a fusion of model no. 1 and no. 3. I suggest the following visualisation of this organisational model.

Figure 5



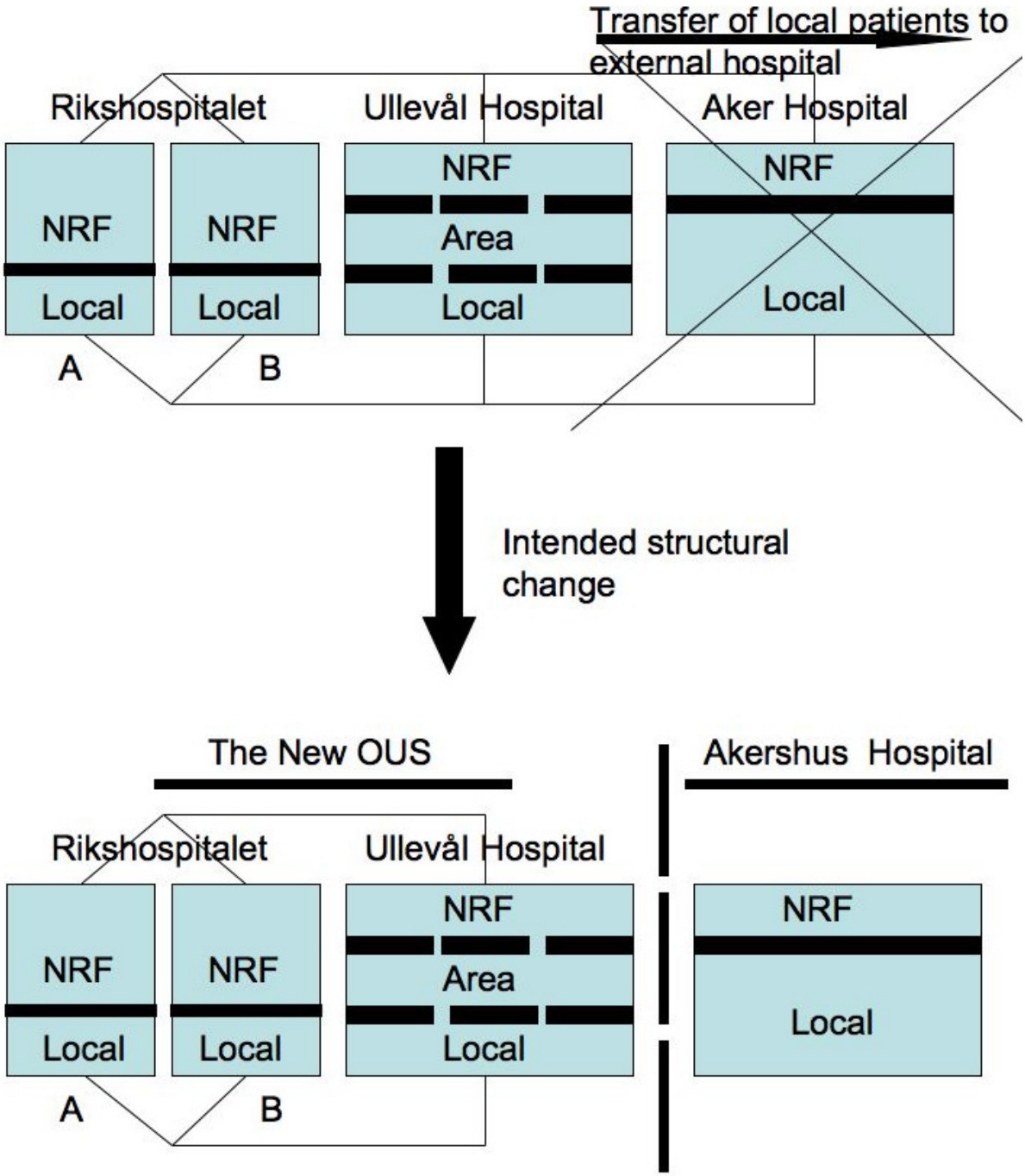
Model's main characteristic is a clearer differentiation between the respective functions of the three hospitals, with Rikshospitalet being NRF oriented and Aker Hospital local functions' oriented, while allowing Ullevål Hospital to develop some middle ground functions on the functional areas of NR and local character. The lines between Hospitals are purposely drawn

both at the bottom of the graph and on top of it. The bottom line represents local patient flow between the Hospitals and the top line shows NR patient flow. Altogether, the bottom and the top lines connect the Hospitals into a closed circuit, enhancing improved patient flow and continuity of care as well as medical professionals' cooperation within the organisational structure and thereby giving potential quality improvements. A transfer of patients between the Hospitals will be based on geographical principle rather than upgrading/downgrading accordingly to the level of care required. Down- and upgrading of a required level of care will be mostly possible within the walls of both Rikshospitalet and Ullevål Hospital, but partly possible in Aker Hospital due to the Hospital's specialisation in local functions and low percentage of NRF available. The presented structure is horizontal and reflects equality of status of each of Oslo University Hospitals. This structure is very alike the actual functional pattern of the three Hospitals before the process of reorganisation. Rikshospitalet has had more of NRF profile ever since it was established, Ullevål has the responsibility for trauma and emergency patients (area function) in addition to some of NRF and solid local services, Aker on the opposite side has traditionally functioned mostly as a local hospital with a selection of NRFs. The model thereby is not as innovative as it appeared from the original simplified graph. Unless something will be done with one of the elements of the circuit, the model will indeed not represent any particular organisational change.

5.2.2. A Transformation of the Initially Dominant Model no. 3, into a Full Picture of the Reorganisation

The below presented model (Figure 6) is a final visualisation of the process of reorganisation as decided by the Board of OUH on 14th of February 2010.

Figure 6



As we can see, the new model is a much further going modification of model no. 3 originally chosen by Siri Hatlen. Presented in this way, its' innovative aspects become sharper. The main change consists of the elimination of one of the elements of the previous circuit and the inclusion of one public and two private hospitals (A-hus, Lovisenberg and Diakonhjemmet are not presented in the above model). The hospital functions of different levels are clustered

in vertical columns. There have been created precisely ten clinics across Rikshospitalet and Ullevål Hospital, with a central managerial unit physically located at Ullevål.

After the period of intensive discussions on the details of reorganisation initialised in August 2009 and fulfilled in totally three phases, the final decision was officially made during the meeting of OUH's board on 17th of February 2010. Norway's capital city's local hospital's function was decided to be concentrated in Ullevål Hospital. Administrative Director, Siri Hatlen, was given the power of attorney to examine the possibilities of sale of Aker Hospital's sites. The mile-stone underlying this decision is referred to another more global decision made by the Board of South-East Regional Health Authority back in 2008 (108/2008) concerning the transfer of the responsibility for 160.000 patients from Alna and Follo to newly established Akershus University Hospital situated in Lørenskog nearby Oslo. A total reduction of local patient basis for OUH was than close to 40-45% of the total patient basis and left not more than the responsibility for 220.000 local patients for OUH. The transfer of patient- basis was to be fulfilled by 31.12.2010, which gave strong incentives to reduce the surfaces of OUH in a middle-long time perspective which was defined to be by the year 2015. OUH underlined the importance of further dialogue with the Council of Oslo, concerning the possible collaboration on creating local medical centre for Oslo inhabitants in the facilities of former Aker Hospital. In the meantime, medical professionals' environments from Aker would be spread between OUH's facilities and Akershus University Hospital, while the periodically oversized local patient flow would be channelled to two collaborating private hospitals in Oslo: Diakonhjemmet Hospital and Lovisenberg Hospital.

5.2.3. The Origins of the Organizational Models Presented by Siri Hatlen

The first traces of the models of restructuration of the three merged Hospitals are traceable in Administrative Directors presentation from the internal orientation meeting for leaders at level two, the employees' representatives and Hospital management of former Aker, Rikshospitalet and Ullevål University Hospitals. The meeting took place on April the 28th 2009. Although Siri Hatlen did not present the accurate graphical presentation of the possible organisational models, she introduced her viewpoints concerning the architecture and interdependencies of local, regional and national hospital functions (the entire presentation in Norwegian can be found in the Appendix II).

Later on, on the Intranett of OUS (available exclusively for the employees of the Hospital), the overall organisation of OUS was published on May the 25th 2009. Here, the three organisational models were clearly sketched and briefly described. The difference between the models presented was described by Siri Hatlen is as follows:

> *"A principle difference is mainly linked to the grade and level of organisation at which the boundaries between the local, regional and national functions are drawn"*

Siri Hatlen argues briefly for her choice of the organisational model no. 3 by using the following statement:

> *"In the end, I have chosen model no. 3 because the representatives of the all environments involved percept this model as acceptable compromise between the crossing interests that needs to be taken into consideration. It is also a solution that in total takes best care of all the joints of the organisation as well as of the external partners and users. The model provides also a good basis for further organisational development"*

This proposition was further brought to the assembly of Hospital management on June the 2nd 2009 (the presentation from the assembly can be found in the Appendix III) and eventually approved by the Hospital's Board on June the 4th 2009.

Although Siri Hatlen claimed in the end of May 2009 that her choice of the organisational model no. 3 is based on the overall approval from the representatives of all the environments involved, it is hard to understand why a detailed presentation of the proposed models was first brought to the Hospital's management post to Administrative Director's proposition presented in May. It seems that the detailed presentation of the initial models as well as the argumentation for the choice of model no. 3 brought to the leader's meeting in June 2009 was of informative type. If the leaders' assembly of June the 2nd had participated in the evolvement of the models presented by Siri Hatlen, they would not have needed such an introduction into the architecture of organisational restructuring. Based on the presentations brought by Siri Hatlen to the leaders' assembly the management of the Hospital was not particularly familiar with the three models. This could implicate that the creation of the three organisational models occurred at the high managerial level or alternatively was done by Administrative Director herself. Either way, it appears that the process of choice between these three particular organisational models was introduced in a top-down manner.

The initial models presented by Siri Hatlen did not contain the necessary level of details that could have helped understand how the proposed models could be applied to the existing physical structure of the merged Hospitals. This negligence of detail specification could have resulted in an emergence of individual interpretations of the application of the models to the reality.

5.2.4. The Understanding of the Organizational Models

While interviewing the Vice Administrative Director of OUH, Tove Strand, I asked her why one considered exclusively the three organisational models from the beginning of the entire process undergone at OUH level? Tove commented on it in the following way:

> *"(...) People have different perception of what actually is an organisational model. And there have been a few alternatives. The one that has been approved, let's call it the Ullevål model, was the one where we have organised us based upon the patient flow, meaning that we have chosen to place all the treatment levels (the national, regional and local functions) within the same clinic (…). The Rikshospitalets model paid a lot of attention to separating the regional and the national functions and was very well organised (…). The Aker hospital model was a bit out of question in this process (…). From my point of view, we organised ourselves in a manner that Ullevål hospital was to become the emergency hospital while Rikshospitalet was to be the elective one (…)*
>
> *What we have got as a result is a model that has clinics spread geographically and to a high degree adapted to the patient flow, but in addition to that we have attempted to gather the regional functions in Gaustad".*

Tove's description of the models appears interesting for two reasons. Firstly it refers to the three models as to the models originating from the three separate Hospitals. In previous Chapter, section 4.3, I have described the historical background for the reorganisation and recalled the answers that each of the involved Hospitals produced for the purposes of the consultative round initiated by South-East RHA on June the 20th 2008. According to the answers provided, Aker University Hospital together with the City Council of Oslo recommended a choice of a hospital structure that clearly separated local functions from NRFs. The suggested model implicated the centralization of NRF function in Ullevål Hospital and Rikshospitalet, while creating a separate space for local functions in Aker Hospital. It appears that Ullevål Hospital and Rikshospitalet chose an organisational model that allowed

for maintenance of their historical functions clearly dominated by NR tasks. Peter Martin, the Health Unit Chief at the City Council of Oslo commented this organisational choice by the following:

> *"(...) when you look at this organisational chart, you feel tempted to speculate whether it was deliberated directly from the specialities of medical professionals, the highly specialised professionals that as we all know are so powerful in the health sector (...). But what we are most interested in are the results and we have not seen those yet. If they manage to achieve good local functions with the organisational model they have chosen, then we'll be happy about it without a doubt."*

The question is whether this organisational structure is fitted to provide satisfactory local hospital functions? This subject should become an issue of further research robustly founded on patients' surveys.

Finally I wish to recall Jan Erik Thoresen's (the vice administrative director in charge of development and integration of OUH) comments on the temporality of the chosen organizational model:

> *"I believe that the organizational model that we have chosen now, if we treat it in a historical perspective it is just temporary (…) it is a combination of the options that were available and a combination of organizational maturity at a given time as well as a combination of the goals that we have to achieve instantly and these that we can postpone in time (…) and I think that we should not overestimate it here (…) but the patients care relatively little about this organizational model. What they care about is the treatment they receive (…). They demand the availability, quality (…). This said, we will certainly change again if we recognize that what we initially chose was not good enough, because we have to progress."*

The above-cited statement recognises that the initial decision-making concerning the organizational model was based on a limited number of options. It seems to me that it was also underestimated as such, since the decision-makers believed in the temporality of this structure. The above-statement alerts and justifies the upcoming changes in the organizational structure of OUH. It also repeats what I have already pointed by citing Tove Strand's comments, concerning patients' limited role in the process and make it even clearer that the

engineers of the process of restructuration had a highly paternalistic attitude towards the users.

5.3. Identifying the Organizational Profile of the OUH

In the period of time from April 2009 to December 2009 OUH can be considered a closed rational system organisation. The available options of Hospitals' organisation were developed beyond the reach of the majority. Further, the majority was confronted with the choice of the best option out of the three preselected options in a top-down manner. No further modifications to the oversimplified organisational models examined in this period of time were done. The managerial elite of the OUH did not open up for such modifications arising from the bottom of the organisation. At the same time, the preselected organisational models lacked the required level of details and might have led to misunderstanding of the upcoming process.

Was the approval of the common model of reorganisation a conscious decision made on the basis of the full access to the relevant information and common definitions? It appears that the information provided to the majority of the decision makers was poor in details and might have led to misinterpretations of the impact of the organisational models on the actual organisational form. Due to the lack of solid expertise of common definitions and understanding at the time of the decision-making in June 2009, the chosen model must have needed further modifications. What was approved then was further processed by the organisation and resulted in an unexpected for many outcome.

The common details' specification was first produced by the Local Hospital Project Group and published on October the 15th 2009, four months after the Hospital Board's approval for the choice of model no.3. The project group explored the number of hospitals, the concept and the localisation of the local hospital.

On December 22nd 2009 OUH initiated a consultative round concerning the further development of the parts of the chosen organisational model. The consultative round intended to bring the focus to the local hospital function. It appears than, that at the level of opened consultative round the focus of the public discussion was intentionally limited to the further development of the chosen model with focus on the local hospital function. The model was

brought in a top-down level, in the same manner as it had occurred internally in the Hospital in April 2009.

Finally on February the 17th 2010, the Hospital's Board decided to open up for sale of former Aker University Hospital. This final decision is closely linked to the initial presentation of the organisational models, the premature choice of the sketch of a model no.3 as well as the final expertise of the Local Hospital Project Group from December 2009. It seems that the opened to public consultative round had little impact on the final decision from February 2010. However, the fact that OUH initiated a public consultative round implicates that it moved from closed-rational towards opened-rational organisational structure. That implicates, that the opinions from the external parts were recorded and even if they have not had a major impact on the development of the structures of OUH, they are traceable and visible in the documentation of the process of reorganisation.

6. FINAL CONCLUSIONS

In this thesis I have attempted to examine the reasons for choice of the implemented organizational model of OUH. The analysis began with a comparison of the goals manifested by the three organizational levels of the studied institution and namely by the State, the South-East RHA and the OUH. Then, I presented the organizational models as initially described by AD of OUH, Siri Hatlen and adjusted to the Hospitals' infrastructure. Further, I explored the origins, understanding and future of the organizational model deployed. I expected to find the inconsistencies throughout the process of restructuration, both between and within some of the organizational levels in accordance with the theory of contingency (Thompson) and theory of Organizational Hypocrizy (Brunsson). I will now shortly reassume my findings and give some recommendations for the further research.

The goals of the process of restructuration of OUH manifested across the three organizational levels did not appear to be conflicting. The largest inconsistencies that I managed to find concerned separation/differentiation of local and national/regional hospital functions. Although some inconsistencies appeared in formulation of the stated strategic goals of restructuration as expressed firstly by South-East RHA and then interpreted by AD of OUH, the overall intentions seemed to be consistent across the organization. The overall premises for the restructuration enhanced patient-oriented changes, cost- and quality improvements, availability and accessibility to the services for all patient groups and last but not least further development of medical science.

Although the goals created at institutional and managerial levels of the organization were transferred to the talk phase of the process at operational level, they did not have the full impact on the further course of action in form of the choice of the final organizational model. This proves a weakened correlation between the State, the South-East RHA and the OUH and confirms the previous foundings by Nerland end Tjerbo concerning the decentralisation of the decision making processes in Norwegian public secondary health care services prior to the Hospital Reform of 2002. It also is in line with the statements of theory of contingency and organizational hypocrisy. The discrepancies arose across the three organizational levels both in stage of talk and the decision making. The politics made on the institutional level (the State) although adapted by the managerial level (the RHA) was not fully transferred to the action undertaken by the operational level of the institution (OUH).

As it concerns the inconsistencies that arose within the single organizational level of the institution, they were manifested though the change of the organizational model presented by Siri Hatlen in June 2008 and the one that was implemented later on in the process undergone within OUH. The former may be a result of a conscious oversimplification of the models' presentation aimed at operationalization. It is also a manifestation of non-responsiveness of the organization to the internal (institutional and managerial) and external recommendations. This combined with the paternalistic approach to the patients concerned, confirms that OUH during the first year of its' existence was a closed rational organization with a strong action-orientation. It implicates as well that the choice of the models was accomplished within a narrow internal managerial group in OUH. The chosen model is based on function's principle, and clusters the activities according to the medical speciality involved. There are some indications saying that this verticality of the chosen organizational model might imply that the process of restructuration was an object of particularly strong influences of medical professionals' groups. It is however highly unsure whether this type of organization is in conflict with patients' interests. Further research examining both patients' satisfaction with the new hospital structure as well as patients' safety issues shall be conducted.

In the end of the first year of the existence of the merger, the Hospital manifested some tendencies pointing at the upcoming change of the organizational profile. A consultative round concerning the localisation of local hospital function was initiated by the Hospital and involved external actors in the formal process of decision-making. This might indicate that in the upcoming phases of the process more users' involvement will be desirable, as the organization will transform from an action-oriented closed rational system to an open natural system actively interacting with its' internal and external environments. This change of organizational profile shall be understood as a continuation of conscious organizational strategy chosen by the management of OUH. The surroundings of OUH are highly dynamic and therefore the survival of the Hospital will be correlated to its' ability to process the input from the different organizational levels as well as the outside world. The organizational model will most probably change in the next phases of the process, as the stage of a major decision-making is temporarily accomplished and the phase of implementation has begun. OUH will probably transform into a natural system in the upcoming stages of the process, and as such it will be steadily more exposed to the demands of both the higher administrative level of public health care system and the societal interests.

List of sources

Boulding K.E.: *The Organisational Revolution,* New York 1953, Harper and Brothers.

Brunsson N.: *The Organisation of Hypocrisy. Talk, Decisions and Actions in Organisations*, Oslo 2006, Universitetsforlaget AS.

Brunsson N. og Olsen J.P.: *Makten att reformera,* Helsinborg 1990, Författarna och Carlsson Bokförlag.

Bull B. and McNeill D.: *Development Issues in Global Governance. Publis Private Partnerships and Market Multilateralism,* Abingdon 2007, Routledge Taylor & Francis Group.

Chambliss D.F. and Schutt R.K.: *Making Sense of Social World. Methods of Investigation,* London 2006, Pine Forge Press.

Egeberg M.: *Organisasjonsutforming i offentlig virksomhet,* Otta 1984, Engers Boktrykkeri A/S.

Fulop N with others: *Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis,* BMJ. Vol. 325 (Aug 3, 2002), pp. 246-249.

Hatlen S.: *Oslo Universitetssykehus. Orientering til ledere på nivå 2 (Aker, Rikshospitalet og Ullevål) og til tillitsvalgte om organisasjon og ledelse,* Oslo 28 Apr, 2009, extracts from Power Point presentation (Appendix II).

Hatel S.: *Oslo Universitetssykehus. Ledersamling,* Oslo 2 Jun 2009, extracts from Power Point presentation (Appendix III).

Høringssvar om utvikling av lokalsykehusfunksjonene (9 Feb, 2009): http://old.oslo-universitetssykehus.no/modules/module_123/proxy.asp?C=1067&I=27246&D=2&mid=

Kumar R.: *Research methodology. A step-by-step guide for beginners,* London 2005, SAGE Publications Ltd.

Lathrop J.P.: *Restructuring Health Care. Tha Petient Focused Paradigm,* San Francisco 1993, Jossey-Bass Publishers.

Lawrence P.R. and Lorsch J.W., *Organisation and Environment: Managing Differentiation and Integration,* Boston 1967, Graduate School of Business Administration, Harvard Univeristy.

Lee T.H., Shiba S., Chapman Wood R.: *Integrated Management Systems. A Practical Approach to Transforming Organizations,* New York 1999, John Wiley & Sons Inc.

Malterud, K.: *The art and science of clinical knowledge: evidence beyond measures and numbers*, THE LANCET. Vol. 358 (Aug 4, 2001), pp. 397-400.

Michels R.: Political Parties, Glencoe 1949, Free Press.

Nerland S.M.: *Effekter av sykehusreformen. Fire essay om mål og viremidler i styringen av spesialisthelsetjenestene,* 2007 Oslo, Series of dissertations submitted to the Faculty of Medicine, University of Oslo, no.457.

Overordnet organisering av Oslo universitetssykehus HF (29 May, 2009): Ullevål intranett/Internettkatalogen/Sykehusnyheter/Overordnet organisering av Oslo universitetssykehus (Appendix I)

Overordnet organisering i Oslo universitetssykehus HF (4 Jun, 2009): http://old.oslo-universitetssykehus.no/modules/module_118/view_case.asp?caseId=698

Posnett J.: *Is bigger better? Concentration in the provision of secondary care,* BMJ. Vol. 319 (Oct 16, 1999), pp. 1063-1065.

Scott W.R.: *Organisations. Rational, Natural and Open Systems,* Englewood Cloffs 1981, Prentice-Hall, Inc.

Sentrale dokumenter Hovedsstadsprosessen: http://old.helse-sorost.no/modules/module_123/proxy.asp?D=2&C=81&I=879

Simon H.A.: *Administrative Behavior,* New York 1957, Macmillan.

Simon H.A.: *On the Concept of Organisational Goal,* Administrative Science Queterly, 9 (June 1964), pp. 1-22.

Suksess gjennom samhandling. Samlet rapport fra Lokalsykehusprosjektet, Oslo Universitetssykehus 4. desember 2009: old.oslo-universitetssykehus.no/stream_file.asp?iEntityId=26338

St.prp. nr. 44 (2006-2007): Om endringer i statsbudsjettet for 2007 under Helse- og omsorgsdepartementet. Tilråding fra Helse- og omsorgsdepartementet av 16. februar 2007, godkjent i statsråd samme dag. (Regjeringen Stoltenberg II): http://www.regjeringen.no/nb/dep/hod/dok/regpubl/stprp/20062007/stprp-nr-44-2006-2007-.html?id=451373

Thompson J.D.: *Organisations in Action,* New York 1967, McGraw-Hill.

Tjerbo T.: *The multileveled governance of health care. An analysis of the Norwegian health care sector,* Oslo 2009, Series of dissertations submitted to the Faculty of Medicine, University of Oslo, no.777.

Utvikling av lokalsykehusfunksjonen i Oslo universitetssykehus – Høring (22 Des 2009): www.oslo-universitetssykehus.no/.../Høringer/Høringsbrev%20lokalsykehus1.pdf

Appendices

Appendix I

Overordnet organisering av Oslo universitetssykehus

Administrerende direktør Siri Hatlen vil ha en organisering som samlet sett ikke gir uakseptabel stor gjennomføringsrisiko for Oslo universitetssykehus. Hun går derfor inn for en organisering på nivå 2 som både samler mange fagmiljø, men som også skiller mellom lokalsykehusfunksjoner og rene lands-/regionfunksjoner. Saken skal behandles på styremøte 4. juni.

- Dette vil føre til en enklere tilrettelegging av "en dør inn"-konseptet, både for lokalsykehuspasienten og regionsykehuspasienten, til det beste for våre pasienter, og slik det er etterspurt av både Oslo kommune og andre helseforetak, sier Hatlen. Et tydeliggjort organisatorisk skille er også en forutsetning for å kunne drive virksomheten i henhold til LEON-prinsippet* som både er riktig for pasienten og for ressursbruken.

> *LEON-prinsippet står for Lavest Effektive Omsorgsnivå, og er et prinsipp om at all forebyggende og helsefremmende arbeid bør foregå i så nær tilknytning til hjemmet som mulig.

Det er i valg av organisering lagt stor vekt på føringene fra Helse Sør-Øst, det foreløpige målbildet for Oslo universitetssykehus, innspill fra viktige samarbeidspartnere (inkludert Oslo kommune, Universitetet i Oslo, høyskolesektoren, andre helseforetak i regionen og andre regioner), samt innspillene og anbefalingene fra prosjektgruppene.

Husk målbilde
- Sammenslåingen av Aker, Rikshospitalet og Ullevål til et felles Oslo universitetssykehus er en stor og krevende oppgave og en fusjon med betydelig størrelse og kompleksitet. Å integrere tre så ulike organisasjoner og kulturer er utfordrende og vil kreve lang tid og stor ledelsesinnsats. Da er det viktig å holde fokus på det foreløpige målbilde som er skissert for Oslo universitetssykehus i arbeidet som nå foregår, sier Hatlen.

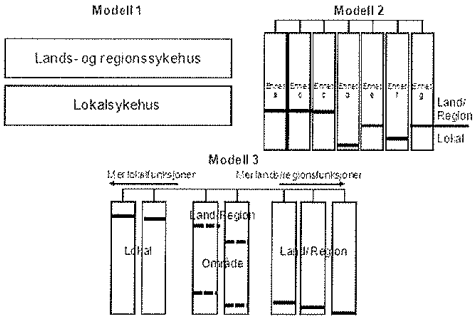
- Vi må synliggjøre at krevende prosesser fører til noe som samlet sett er bedre. Målbildet vil bli konkretisert og videreutviklet, og bygger også på de føringer som er gitt av Helse Sør-Øst i etterkant av Hovedstadsprosessen.

Foreløpig målbilde for Oslo universitetssykehus:

- Høy kvalitet i pasientbehandlingen
- Skape et godt og effektivt lokalsykehus
- Styrking av høyspesialisert medisin
- Best på forskning, utdanning og innovasjon
- Attraktiv arbeidsplass
- Effektiv ressursutnyttelse

Tre modeller vurdert
I arbeidet med overordnet organisering av Oslo universitetssykehus er det vurdert tre alternative hovedmodeller. Alle tre modellene tar utgangspunkt i pasientforløp og identifiserte klynger av disse som aggregeres opp til en overordnet struktur.

- Den prinsipielle forskjellen er i hovedsak relatert til i hvor stor grad, og på hvilket nivå i organisasjonen det skilles mellom lokal- og lands-/regionfunksjoner, forklarer Hatlen.



Se beskrivelse nederst i saken

Alle modellene er vurdert i forhold til åtte definerte designkriterier. Formålet med kriteriene har vært å etablere et felles utgangspunkt for beskrivelse, kvalitetssikring og vurdering av de respektive hovedmodellene og alternative forslag til gruppering av kliniske funksjoner. Det er særlig punktet om gjennomføringsrisiko som har vært utslagsgivende i siste runde.

Valg av modell
- Jeg har til slutt lagt modell tre til grunn fordi denne av representanter for alle miljøene nå oppfattes som akseptabel og et godt kompromiss mellom de kryssende hensyn som må ivaretas. Den er også den løsning som samlet sett best ivaretar alle delene av organisasjonen samt eksterne samarbeidspartnere og brukere. Modellen gir også grunnlag for en god videreutvikling av organisasjonen, sier Hatlen.

Organisering av en virksomhet er i utgangspunktet kun en måte å gruppere aktivitet på for å sikre oversikt og styrbarhet. Ulike modeller har ulike styrker og svakheter, og må derfor suppleres med kompenserende tiltak.

- Vårt organisasjonskart er ikke meislet i stein, og vi må ha rom for justeringer etter hvert som dette utvikles videre, sier Hatlen.

Veien videre
Det skal nå ansettes ledere på nivå 2 og det skal parallelt utarbeides forslag til planer og mandater for det videre arbeid.

Det blir opprettet et eget prosjekt for å tydeliggjøre og utvikle hele konseptet for lokalsykehusfunksjonen i Oslo universitetssykehus. Dette vil gjøres i nært samarbeid med Oslo kommune, Ahus og øvrige samarbeidsparter.

Hele styresaken kan leses på styresidene på www.oslo-universitetssykehus.no.

Forklaring til modellene
Modell 1 har et konsekvent skille mellom lokalsykehusfunksjoner og Lands-, region-, og områdefunksjoner på nivå 2. Fagmiljøene er delt opp etter denne oppgavefordelingen.

Modell 2 har ingen skille mellom lokalsykehusfunksjoner og Lands-, region-, og områdefunksjoner på nivå 2. Alle fagmiljøene er samlet på tvers av funksjonsnivå.

Modell 3 kan karakteriseres som en kombinasjon av modell 1 og 2, med et tydeligere skille mellom lokalfunksjonen og lands-/regionfunksjonen. Samling av fagmiljø er ikke fullstendig

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Appendix II

The extracts from Siri Hatlen's presentation from 28 Apr 2009

Oslo universitetssykehus

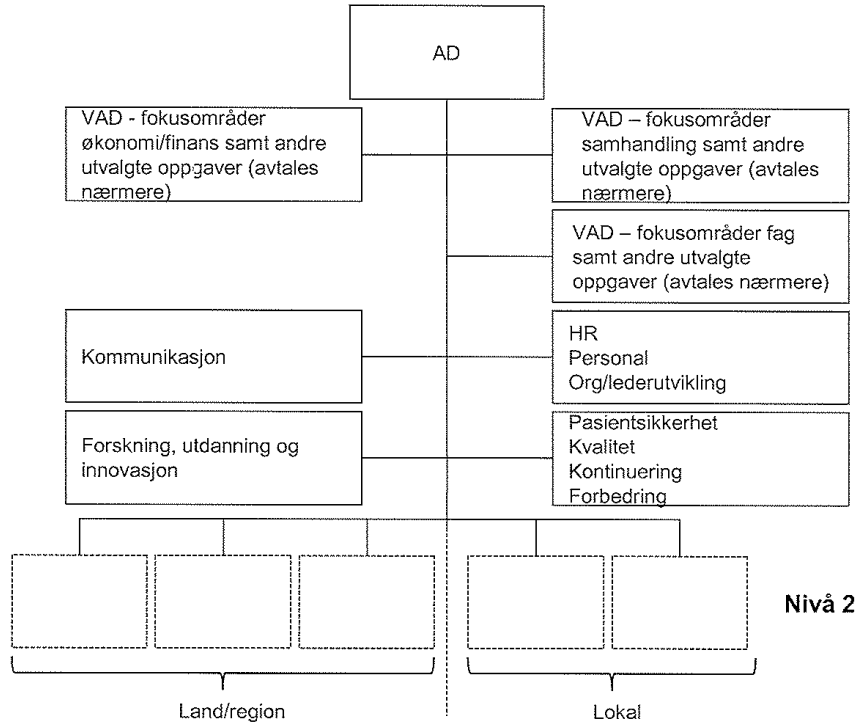
Orientering til ledere på nivå 2 (Aker, Rikshospitalet og Ullevål) og til tillitsvalgte om organisasjon og ledelse

28. april 2009
Siri Hatlen

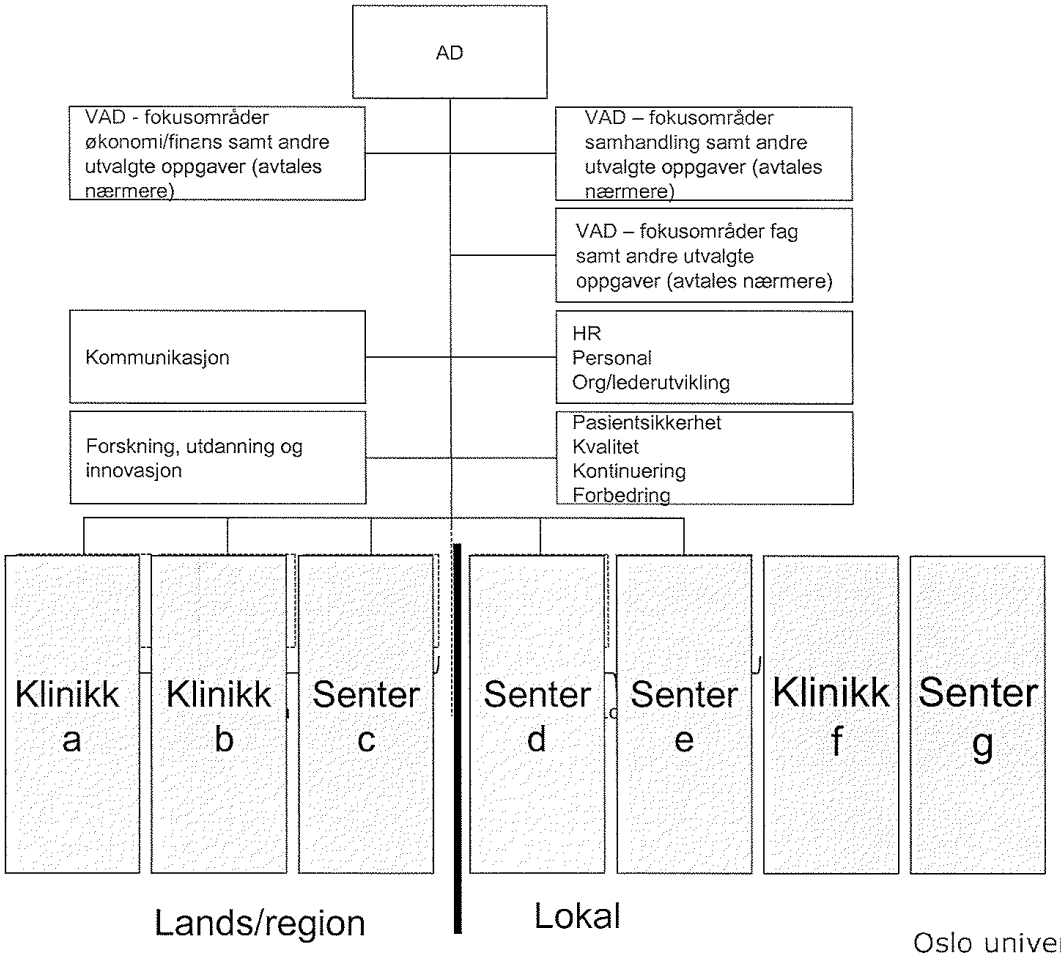
Oslo universitetssykehus

HELSE SØR-ØST

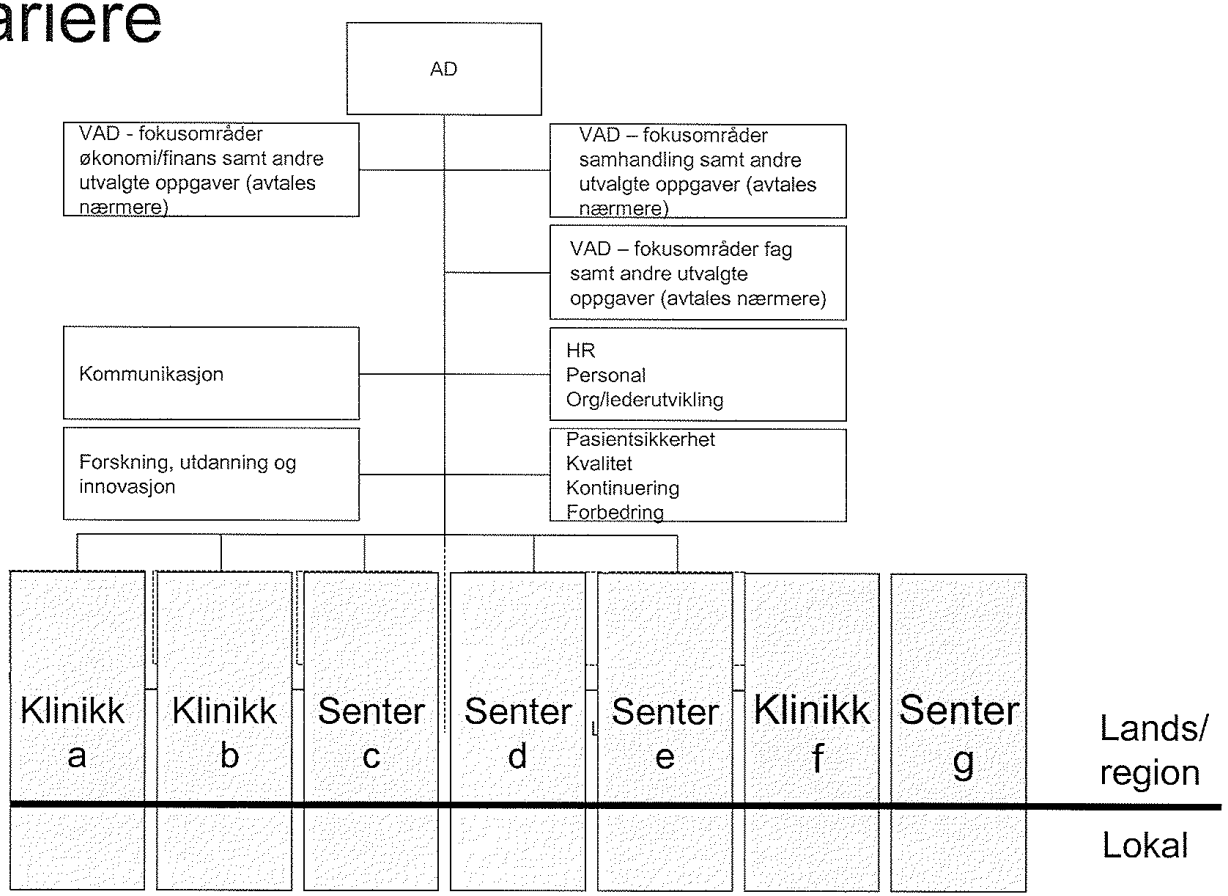
Prinsippskisse for overordnet organisasjonsstruktur



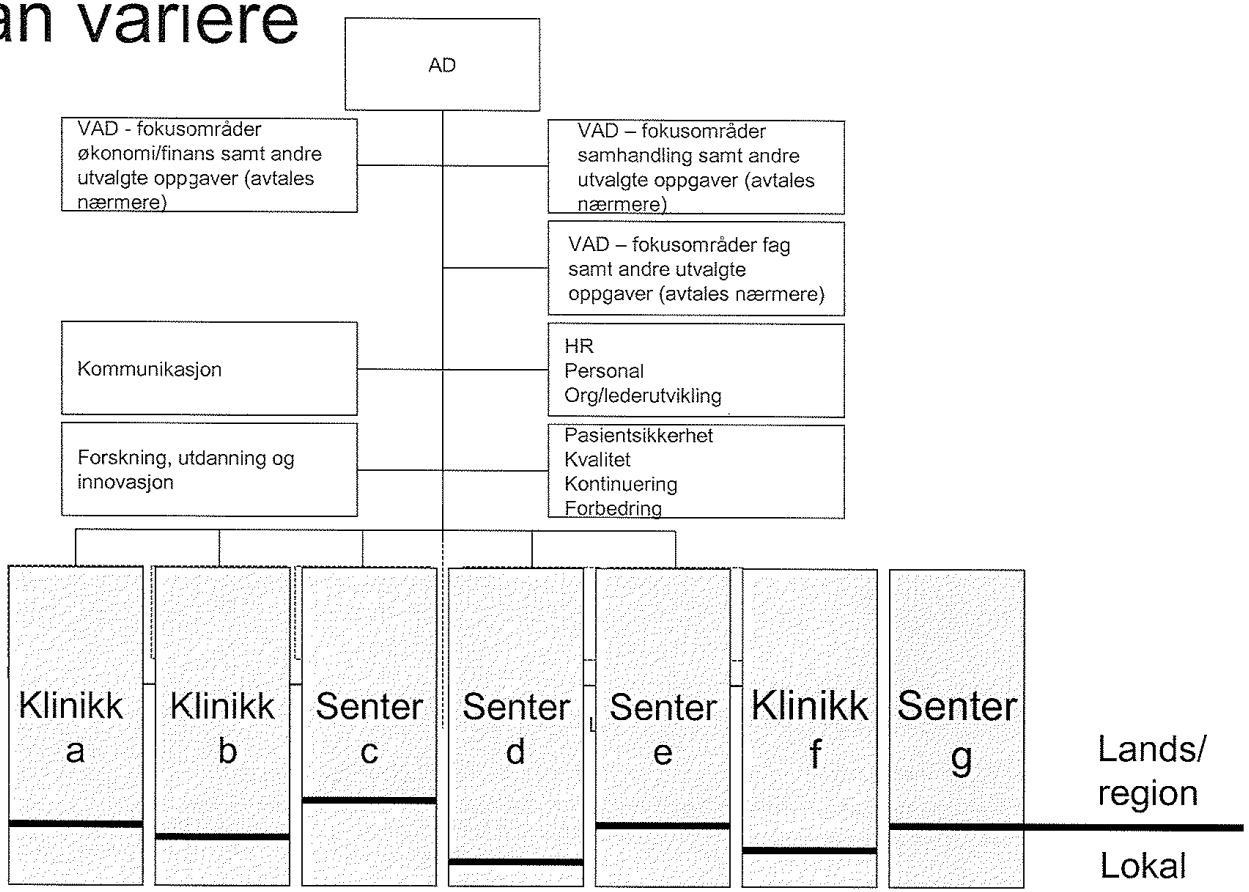
Målet er å finne en fleksibel organisasjonsform



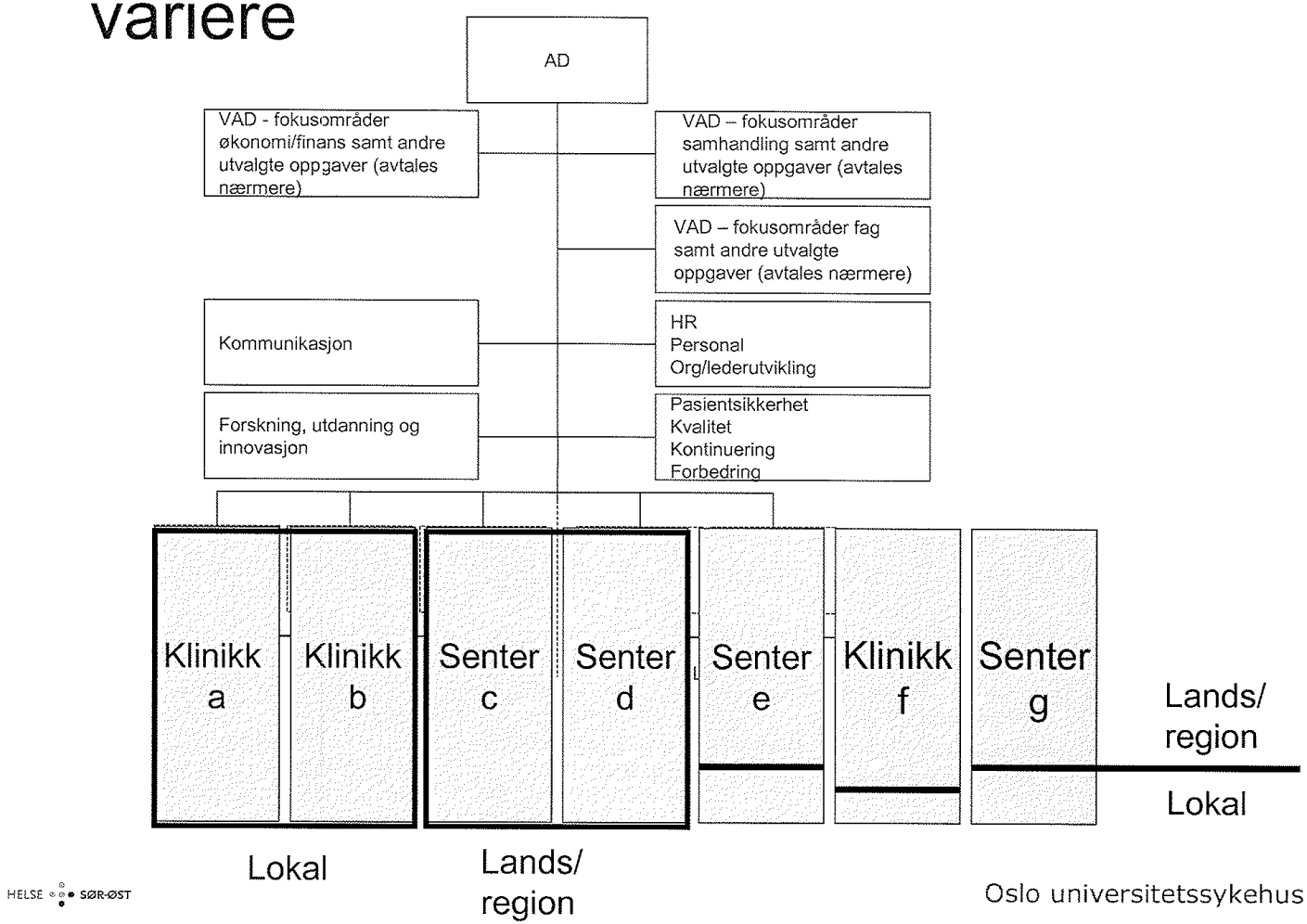
Fordelingen av land/region vs lokal kan variere



Fordelingen av land/region vs lokal kan variere



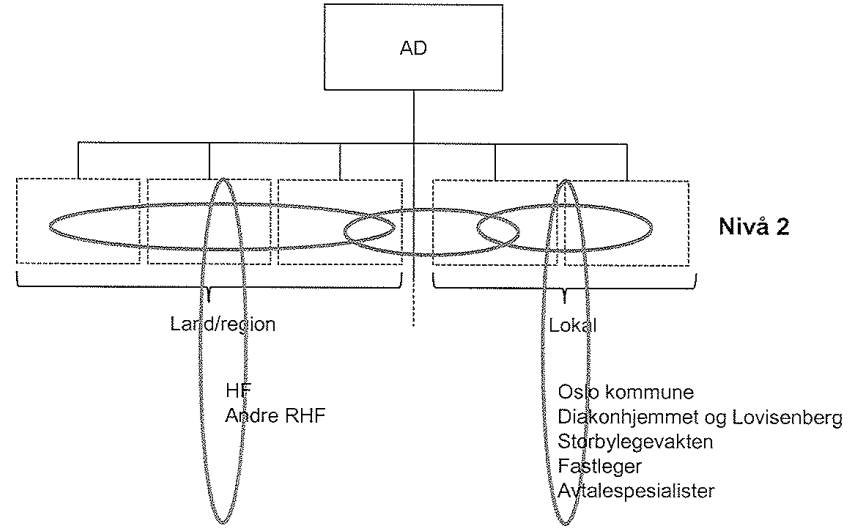
Fordelingen av land/region vs lokal kan variere



HELSE SØR-ØST

Oslo universitetssykehus

Pasientforløp er både interne og eksterne - mer oppmerksomhet om eksterne i neste fase



- Storby-/ og lokalsykehusfunksjonen
  - Gode pasientforløp med organisatoriske grenseflater mot Oslo kommune, storbylegevakten, fastleger, avtalespesialister, de private ideelle sykehusene
- Lands-/ og regionssykehusfunksjonen
  - Samorganisering av alle regionsfunksjoner
  - Gode pasientforløp og tydelige grenseflater mot andre sykehusområder og andre regioner

Appendix III

The extracts from Siri Hatlen's presentation from 2 Jun 2009

Oslo universitetssykehus

ledersamling Ullevål

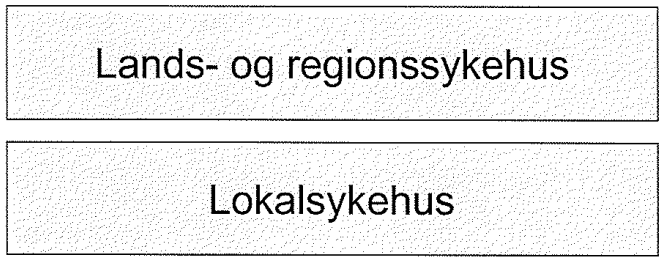
Siri Hatlen
2. juni 2009

HELSE SØR-ØST

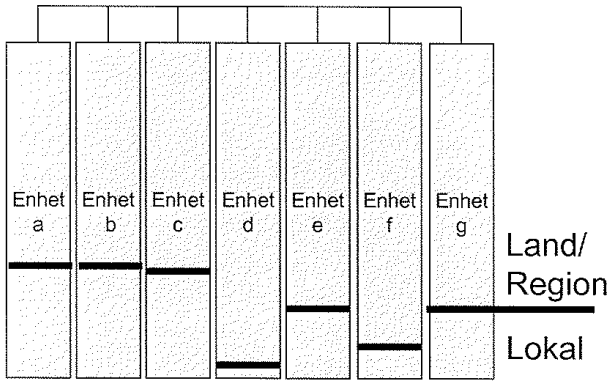
Oslo universitetssykehus

Tre prinsipielle modeller er vurdert

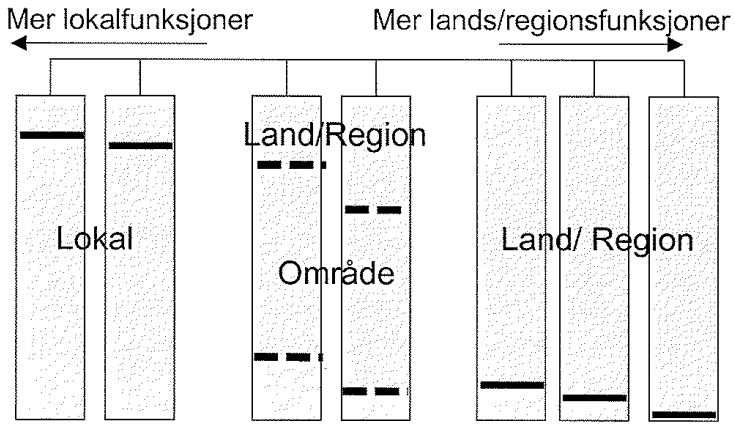
Modell 1



Modell 2



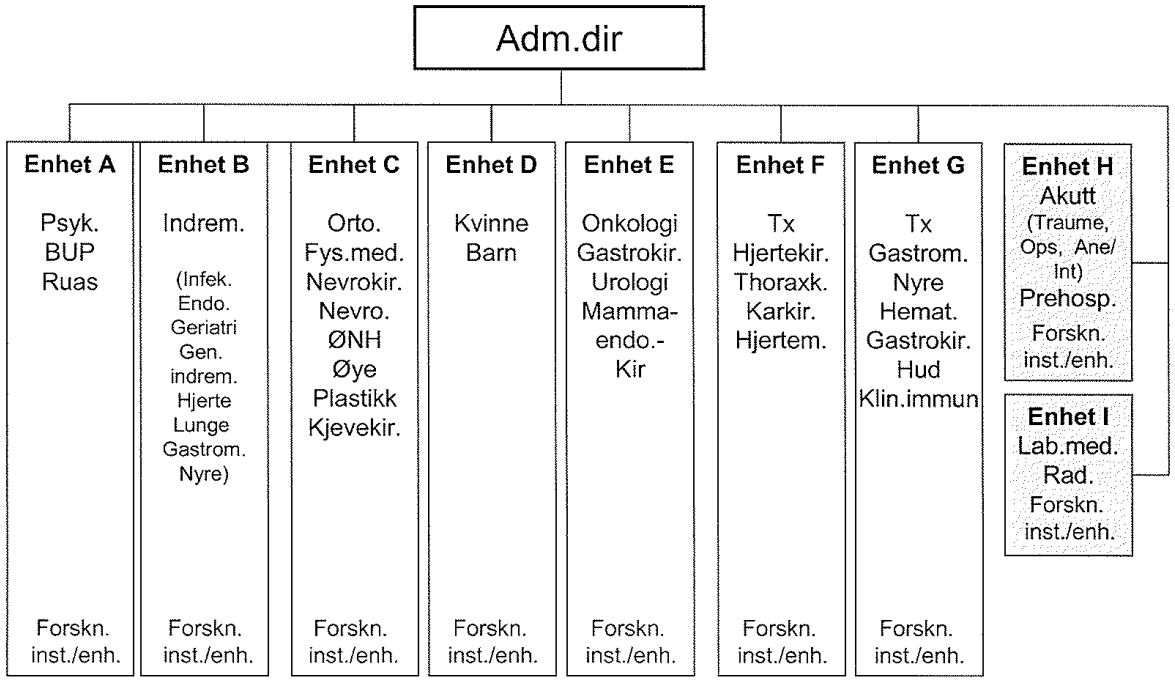
Modell 3



Modellene

- **Modell 1** har et konsekvent skille mellom lokalsykehusfunksjoner og LRO-funksjoner (Lands-, region- og områdefunksjoner) på nivå 2. Fagmiljøene er delt opp etter denne oppgavefordelingen.
- **Modell 2** har ingen skille mellom lokalsykehusfunksjoner og LRO-funksjoner på nivå 2. Alle fagmiljøene er samlet på tvers av funksjonsnivå.
- **Modell 3** kan karakteriseres som en kombinasjon av modell 1 og 2, med et tydeligere skille mellom lokalfunksjonen og lands/ regionfunksjonen. Samling av fagmiljø er ikke fullstendig.

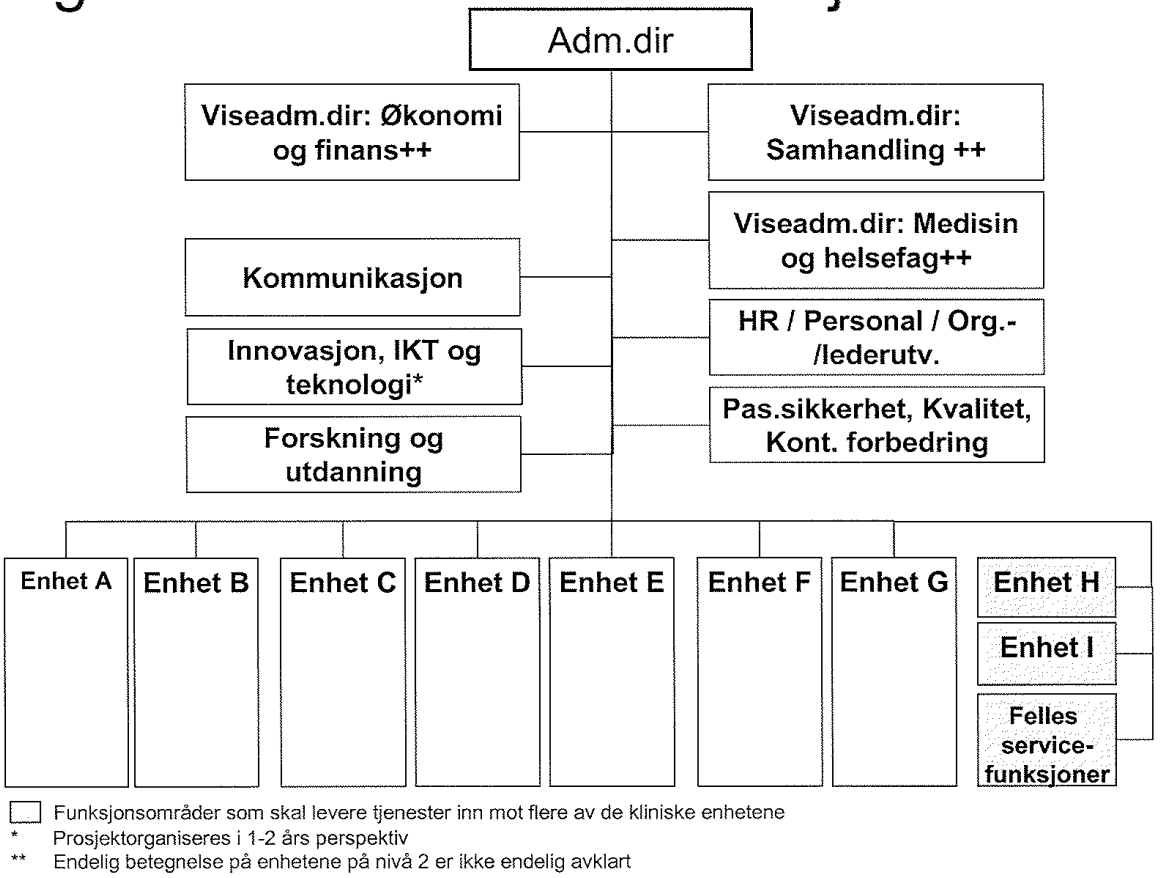
Adm.dir.anbefaler organisering av klinisk aktivitet basert på modell 3



Konklusjon modell 3

- Modellvalg gir samlet sett ikke uakseptabel stor gjennomføringsrisiko for Oslo universitetssykehus
- På nivå 2 samles mange fagmiljø samtidig som det er skiller mellom lokalsykehusfunksjoner og rene lands-/regionfunksjoner
- Modellen legger til rette for "en dør inn"-konseptet, både for lokalsykehuspasienten og regionsykehuspasienten
- Et tydeliggjort organisatorisk skille er en forutsetning for å kunne drive virksomheten i henhold til LEON-prinsippet
- Modellen tar høyde for de ulike miljøenes innspill og er et godt kompromiss mellom mange kryssende hensyn

Stab- og støtte, fellestjenester og ikke- medisinske servicetjenester



Funksjonsområder som skal levere tjenester inn mot flere av de kliniske enhetene

* Prosjektorganiseres i 1-2 års perspektiv

** Endelig betegnelse på enhetene på nivå 2 er ikke endelig avklart